CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Yohan Wepitiya-Gamage
Hearing dates:	2 December 2021
Date of findings:	9 December 2021
Place of findings:	Coroners Court Complex at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, self-inflicted death, Metropolitan Special Programs Centre, psychiatric review, Patient Administration System, Darcy Daily Clinic Tracker Sheet, cell architecture, ligature points, cell placement
File number:	2016/24535
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Ms B Kennedy for the family of Mr Wepitiya-Gamage Ms K Kumar, instructed by Hicksons Lawyers, for Justice Health & Forensic Mental Health Network Mr T Saunders, instructed by Meridian Lawyers, for Dr G Elliott Ms E Trovato for Commissioner of Corrective Services New South Wales
Findings:	Yohan Wepitiya-Gamage died on 22 or 23 January 2016 at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036. The cause of Yohan's death was hanging. Yohan died, whilst in lawful custody, as a result of actions taken by him with the intention of ending his life.

Recommendation pursuant to s 82 Coroners Act 2009:	I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network, that the Custodial Mental Health Operations Manual be updated to reflect the introduction and use of the Darcy Daily Clinic Tracker Sheet.
Non-publication orders:	See Appendix A

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1. Introduction

1.1 On the morning of 23 January 2016 Yohan Wepitiya-Gamage was found suspended from a ligature, with no signs of life, inside a cell at a correctional centre. Yohan was only 19 years old and had entered lawful custody some six weeks earlier on 15 December 2015.

1.2 Following a mental health assessment conducted on 24 December 2015, it was identified that Yohan required a review by a psychiatrist. However, due to an administrative error this review, which should have occurred prior to 23 January 2016, did not take place.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, although an inquest into Yohan's death is mandatory, by virtue of him being in lawful custody at the time of his death, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family like Yohan's to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to

systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Yohan's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Yohan's life in a brief, but hopefully meaningful, way.

3.3 Yohan was born in Germany in 1996 and had three sisters, SG, MG and NG. Yohan's mother and sisters later moved to Australia whilst his father remained living in Germany. The family lived in a number of different locations in the western suburbs of Sydney before eventually settling in Pendle Hill.

3.4 As a young boy Yohan used to attend church on a regular basis. He was fond of many sports and activities such as cricket, football, and dancing. Yohan was also a talented singer.

3.5 After leaving school early, Yohan worked in a variety of casual roles with his last job working for a transport company. Yohan enjoyed this role, and both he and his family found the stability that the job brought to his life to be encouraging.

3.6 One of Yohan's sisters describes him as being entirely selfless and someone who was always ready and willing to help a friend, or someone, in need. He was a source of advice, support and wisdom for many of his friends, and displayed a maturity beyond his years. One of Yohan's best friends recalls a time when she was faced with the prospect of having nowhere to live and turning to Yohan for help. He provided her with some clothes and welcomed her into his home. More importantly, Yohan provided the emotional support to his friend to ensure that she felt safe and secure. Yohan's friend describes him as the kindest soul she ever met.

3.7 Another one of Yohan's friends fondly recalls him to have been such a humble and caring person. The care that Yohan had for others was reciprocated by his family and many friends. The significance of Yohan's loss to them, and the impact that Yohan had on their lives, is evident from the fact that over 600 people attended Yohan's funeral. All of them no doubt were touched in some way by Yohan's infectious energy and zest for life, his compassion for others, and his cheeky attitude to life and warm smile.

3.8 Yohan was, and still is, deeply loved by his family and greatly missed. Yohan's family lovingly supported him through the challenges that he faced in his life. It is most upsetting to know that Yohan has been taken from them at such a young age.

4. Yohan's previous custodial and medical history

4.1 Yohan first became involved with the criminal justice system in 2013. He was dealt with in the Children's Court jurisdiction for a number of dishonesty and anti-social offences, with some resulting in periods of detention.

4.2 In December 2014 Yohan had his first experience of being dealt with in the Local Court jurisdiction. He was later convicted and sentenced to a custodial sentence with a non-parole period between March and May 2015.

4.3 According to available medical records Yohan reported experiencing psychotic symptoms, auditory hallucinations and paranoia in 2013. It was thought at the time that this may have been related to Yohan's use of cannabis and other illicit drugs. It appears that as a result of Yohan's contact with the criminal justice system in 2014 he was referred to Headspace in September 2014, a national youth mental health foundation providing early intervention mental health services for young adolescents and young adults.

4.4 According to Headspace records, by at least December 2014 Yohan had been diagnosed with a first episode of psychosis.[1] This resulted in Yohan's involvement in Headspace's Youth Early Psychosis Program (**YEPP**). However, in early 2015 Yohan unfortunately failed to engage with Headspace by not attending appointments. This lead to Yohan's YEPP referral being closed in April 2015. Further, Yohan continued to use illicit drugs and engage in criminal activity, ultimately leading to him being convicted and incarcerated, as noted above.

5. The period of custody leading up to, and at the time of, Yohan's death

5.1 On 15 December 2015 Yohan was arrested and charged in relation to an alleged offence of interpersonal violence involving the use of a weapon. He was subsequently refused bail and remanded into the custody of Corrective Services NSW (**CSNSW**).

5.2 Yohan was initially received at the Metropolitan Remand and Reception Centre (**MRRC**) in Silverwater. As part of the reception assessment process, a Health Problem Notification Form (**HPNF**) was created which noted that Yohan had a history of self-harm, depression and alcohol abuse. Accordingly, he was placed on a Risk Intervention Team (**RIT**) protocol.[2] Instructions were given for Yohan to be placed in a camera assessment cell with 30 minute observations, and that he was to have nil sharps and minimal possessions until he had been cleared by a RIT review, and by a

[1] Exhibit 1, tab 17.

[2] A RIT protocol provides an interdisciplinary mechanism for staff from both CSNSW and Justice Health to identify, assess and intervene when an inmate is at risk and/or making self-harm attempts. The aim of placing an inmate under a RIT Protocol is to assess an inmate's risk factors, ensure the inmate's safety, ensure the effective development and implementation of an individual management plan, to ensure appropriate specialise referral where applicable, and to provide continuity of crisis and case management care.

drug and alcohol nurse.[3] A Mandatory Notification Form (**MNF**) for offenders at risk of suicide or self-harm was also completed.

5.3 On 18 December 2015 Yohan was reviewed by a RIT. Notes taken during the review record that Yohan had no "*previous or current thoughts of self-harm and suicidal ideations*".[4] A further MNF was completed noting that Yohan's level of risk diminished because he had guaranteed his own safety. Accordingly, a RIT Management Plan was completed which noted that Yohan was suitable for two-out cell placement (sharing a cell with another inmate) but was to remain in the MRRC reception pod until he had been cleared, following review by a drug and alcohol nurse, to be transferred elsewhere.

5.4 On 20 December 2015 Yohan was reviewed by a drug and alcohol nurse and he was noted to be alert and indicating that he was feeling better. He was subsequently cleared from detox and remained in shared cell placement until he had been cleared by a mental health review.

5.5 On 23 December 2015 a mental health assessment was completed for Yohan. A risk assessment noted that Yohan had no recent thoughts, plans, symptoms or behaviour indicating or suggesting risk. Further, the assessment noted that Yohan's level of risk did not appear to be highly changeable, that he was a low risk of suicide, and that a more detailed assessment of suicide risk was not required.[5]

Psychiatric review

5.6 Yohan was subsequently reviewed by a psychiatrist, Dr Gordon Elliott, on 24 December 2015. The progress notes from that review record that Johan reported that being in custody was "*a bit stressful*" and that he felt "*pretty drained emotionally*". Yohan also reported that his physical health generally was "*pretty good*" but that his appetite had been poor. On assessment no evidence of affective or cognitive deficits were found and it was noted that Yohan displayed no current psychotic symptoms. It was also noted that Yohan denied any thoughts of self-harm or suicide. According to the progress notes, the impression formed by Dr Elliott was that Yohan had a history of drug-induced psychosis and that Yohan's complaints of paranoia were more consistent with anxiety.[6]

5.7 Dr Elliott also cleared Yohan from the Darcy Unit to a normal cell placement in the main population. Dr Elliott noted:

> This would allow him to move to a relatively quiet and generally more predictable pod environment than Darcy, and one in which he would find it easier to get his needs met, such as access to the phone and more regular exercise.

5.8 Relevantly, Dr Elliott also indicated that Yohan would require a formal psychiatric review in four weeks. As to the rationale for this, Dr Elliott explained:

[3] Exhibit 1, tab 12.
[4] Exhibit 1, tab 12.
[5] Exhibit 1, tab 15.
[6] Exhibit 1, tab 15.

> I did not consider [Yohan] represented a significant risk of self-harm although, given his history of psychosis, I did believe he warranted a further psychiatric assessment to review his treatment with risperidone, including a check for side effects, and his mental state more generally.

One-out cell placement

5.9 On 25 December 2015 Yohan was cited for fighting with other inmates. He was reprimanded and cautioned and confined to his cell for two days. The following day, 26 December 2015, Yohan was placed alone in a one-out cell as he had threatened violence against his cellmates. Following this, an alert was placed on Yohan's CSNSW Offender Integrated Management System record which stated:

> Inmate must be placed 1-out until reviewed by Mental Health. His cell mates have reported that he constantly threatens violence towards them and makes comments like, 'I'd like to know what it's like to stab someone and kill them'. While it is impossible to verify these statements, the same comment has been made by enough inmates to make me concerned that he will engage in some kind of violent act against others.

5.10 A HPNF completed on 29 December 2015 noted that Yohan had been cleared by a psychiatrist and, following a mental health assessment, that he was suitable for normal cell placement. This categorisation meant that Yohan could be placed in either a one-out cell or in a shared cell.

Review on 3 January 2016

5.11 At around 4:00pm on 3 January 2016 Yohan was reviewed by Registered Nurse (**RN**) Patricia Guilfoyle. This was not a pre-booked appointment, but rather a new mental health assessment. Available records indicate that this review was related to a "*recent assault*". Case reports kept by CSNSW indicate that Yohan was involved in a verbal argument with another inmate on the same day, with the potential for physical interaction. As a result of the incident, Yohan was removed from the area and placed in different accommodation.

Transfer to Metropolitan Special Programs Centre

5.12 On 19 January 2016 Yohan was transferred to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex. He was moved there as a remand bed placement. This is a strategy used by CSNSW to optimise bed space and is used for inmates who have been given a future court attendance date. In Yohan's case he was next due to appear at court on 11 May 2016. A progress note entry recorded at 4:00pm on 19 January 2016 noted that Yohan denied having any medical issues and guaranteed his safety.[7]

5.13 Yohan also took part in an interview with a CSNSW Service and Programs Officer on 20 January 2016. Records note that at the time Yohan did not have any current thoughts of self-harm and that he did not have any immediate concerns or issues. It was also noted that Yohan remained suitable for normal cell placement.[8]

[7] Exhibit 1, tab 15.
[8] Exhibit 1, tab 12.

6. What happened between 20 and 22 January 2016?

6.1 Upon his arrival in the MSPC Yohan was housed in 9 Wing. This is an accommodation unit that houses remand bed placements and inmates in transit to regional correctional centres. At the time of Yohan's arrival, one of his friends, Jake Milojevic, was also housed in 9 Wing in the MSPC. Mr Milojevic occupied cell 67 with another inmate, George Tzanis, who had never previously met Yohan. Both Mr Milojevic and Mr Tzanis had been in custody since November 2015. Mr Tzanis described Yohan and Mr Milojevic as being "*excited*" when they first saw each other.[9] He also said that he saw Yohan and Mr Milojevic "*in the yard a bit mucking around and talking*".[10]

6.2 Yohan was placed in cell 66, adjacent to the cell occupied by Mr Milojevic and Mr Tzanis. Initially, Yohan shared his cell with another inmate. Mr Milojevic spoke to Johan's cellmate to ask how Johan was and was told that "*he was alright*".[11] Later, Mr Milojevic had a chance to have a "*good talk*" with Johan and that "*he seemed normal*".[12] Yohan's cellmate was later moved from the cell on Wednesday 20 January 2016.

6.3 On Wednesday, 20 January 2016 Mr Milojevic described Johan as being "*very quiet and cut off from everyone*".[13] Mr Milojevic asked Johan why he was keeping to himself. When his friend asked about him Yohan told his friend that he was "*just kicking back*".[14] Yohan's friend believed that nothing was amiss as he understood that "*sometimes you just need to relax by yourself in gaol*".[15]

6.4 Mr Milojevic describes Yohan to be the same on Thursday, 21 January 2016. He said that Yohan was "*very quiet*" and that he did not see him talking to anyone, and said that "*he just stayed by himself and kicked back*".[16]

6.5 Mr Milojevic described Johan as being the same on Friday, 22 January 2016. Mr Tzanis also saw Yohan on Friday, 22 January 2016. He said that Yohan "*looked to me to be depressed because he had his head down to the ground and he was looking up every time I walked up to him and then he would put his head down again*".[17]

6.6 Mr Tzanis said that he formed the view that Johan "*seemed like a very depressed guy when I met him*" but did not know if this was how Yohan usually appeared.[18] At some stage between 20 and 22 January 2016 it appears that Mr Tzanis mentioned this observation to Mr Milojevic who told him that Yohan "*was the kind of guy you have to look out for because he's a quiet guy but he can just snap*".[19]

[9] Exhibit 1, tab 10 at [4].
[10] Exhibit 1, tab 10 at [4].
[11] Exhibit 1, tab 9 at [8].
[12] Exhibit 1, tab 9 at [9].
[13] Exhibit 1, tab 9 at [10].
[14] Exhibit 1, tab 9 at [10].
[15] Exhibit 1, tab 9 at [10].
[16] Exhibit 1, tab 9 at [11].
[17] Exhibit 1, tab 10 at [6].
[18] Exhibit 1, tab 10 at [9].
[19] Exhibit 1, tab 10 at [9].

7. What happened on 22 and 23 January 2016?

7.1 Yohan was locked in his cell at about 2:30pm on 22 January 2016. At around 7:00pm an inmate in a neighbouring cell to Yohan's heard what he described as "*the door banging two [sic] or three kicks of punches*".[20] At just before 8:30pm the inmate heard what he described as "*a couple more bangs or kicks on the door*".[21] The sounds did not cause the inmate to believe that anything was amiss.

7.2 At about 7:20am on 23 January 2016 CSNSW officers began conducting a head check in the wing where Yohan was housed. Yohan's cell door was opened at about 7:25am and he was found suspended from his CSNSW jumper which had been tied around his neck and fastened to the bars of his cell window.

7.3 The CSNSW officers immediately lowered Yohan to the ground and commenced cardiopulmonary resuscitation whilst also calling for assistance from Justice Health & Forensic Mental Health Network (**Justice Health**) staff and emergency services. Justice Health staff arrived on scene at about 7:27am with a defibrillator and oxygen tank and mask. Resuscitation attempts continued until the arrival of paramedics from NSW Ambulance but Yohan remained unresponsive with no signs of life. Yohan was later pronounced life extinct at 7:42am.

7.4 Investigating police later attended the scene at around 9:30am. They found three notes written by Yohan in his cell. All three notes were addressed to members of Yohan's family. In the notes Yohan expressed his inability to continue with life and bade farewell to his family, expressing his love for them.

8. What was the cause and manner of Yohan's death?

8.1 Yohan was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay on 28 January 2016. A faint, broad-based red ligature mark with occasional fine, horizontal abrasions present around the neck was identified. In the autopsy report dated 24 January 2017, Dr Szentmariay opined that the cause of death is hanging.

8.2 Three matters are relevant to the manner of Yohan's death:

(a) The observations made of Yohan by Mr Milojevic and Mr Tzanis between 20 and 22 January 2016, when it appeared that Yohan was showing signs of low mood;

(b) The circumstances in which Yohan was found on the morning of 23 January 2016; and

(c) The notes written by Yohan which contained content consistent with an intention to self-harm.

8.3 Having regard to the above, there is sufficiently clear and cogent evidence to allow for a conclusion to be reached that Yohan died as a result of actions taken by him with an intention of ending his life. Therefore, Yohan's death was intentionally self-inflicted.

[20] Exhibit 1, tab 10 at [8].
[21] Exhibit 1, tab 10 at [8].

9. What issues did the inquest examine?

9.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

(1) Did Justice Health comply with its policies and procedures in relation to the care and treatment of Yohan during his time in custody?

(2) What measures have Corrective Services NSW put in place to safeguard and minimise actual or potential ligature points within the Metropolitan Special Programs Centre since 23 January 2016?

(3) Is it necessary or desirable to make recommendations in relation to any matter connected with Yohan's death?

10. Compliance by Justice Health with relevant policies

Follow-up appointments

10.1 As at December 2015 there was both an electronic and paper-based administration system used by Justice Health relevant to the management of inmate patients.

10.2 First, Justice Health utilised the Patient Administration System (**PAS**), a centralised patient booking system used to record referrals and medical appointments for patients, and to ensure that scheduled appointments are easily identified. Relevantly, Justice Health staff within Darcy Unit used PAS to make initial and follow-up appointments for a patient with a psychiatrist.

10.3 Second, Justice Health staff also utilised the following paper-based processes:

(a) As at December 2015, a Daily Appointment Sheet (**Daily Sheet**), which would be printed from PAS by a clinical support officer, and which provides a list of all patients booked into a clinic on a particular day. The Daily Sheet contains a number of tick boxes to identify whether a patient has attended the clinic, and whether a review or follow-up appointment is required. If such a review or follow-up appointment is required, the date of the relevant appointment is also recorded. The relevant clinician (for example, a nurse or psychiatrist) is responsible for completing the Daily Sheet. Once completed, the Daily Sheet is provided to administrative staff so that information can be entered onto PAS.

(b) At some time after December 2015, a Darcy Unit diary (**the Diary**) was kept in the psychiatrist's office and updated by a psychiatrist following each patient review. The Diary is used by psychiatrists to record follow-up appointments, together with essential notes regarding each patient has been seen. At the end of each day, the Diary is photocopied and sent to administrative staff so that PAS can be updated accordingly. Nursing staff use information contained within the Diary to initiate any follow-up action that is required, and also review the Diary the day after a patient is seen to ensure that nothing is missed.

The 24 December 2015 Daily Sheet

10.4 The Daily Sheet for 24 December 2015 lists a number of inmates, including Yohan, with appointments to see Dr Elliott on that day. Whilst the tick boxes for a number of inmates are ticked, and there are handwritten notations indicating the date by which a follow-up appointment is to be made, there are no similar notations regarding the entry for Yohan.

10.5 Dr Elliott explained the function and purpose of the Daily Sheet in this way:

> [It] was used, in combination with the diary, to handover in a succinct format the essential recommendations for each patient seen on the day […] The [Daily Sheet] was used to indicate whether a patient had actually been seen and provide a recommended psychiatric follow-up time.

10.6 Despite the above, Dr Elliott did not complete the relevant entry for Yohan in the 24 December 2015 Daily Sheet. Instead, Dr Elliott recorded an entry in the progress/clinical notes for that day noting that Yohan was for psychiatric review in four weeks' time (using the abbreviation "*Ψ rv 4 weeks*"). However, Dr Elliott acknowledged that typically this progress notes entry "*would only be seen by nursing and medical staff subsequently assessing [Johan]*, and not by administrative staff so that an appointment for the review could be booked in PAS.

10.7 Dr Elliott recognised that he should have instead both noted that Yohan had been reviewed, and provided a follow-up appointment time on the Daily Sheet, so that a follow-up appointment could then be booked in PAS. As to these omissions, Dr Elliott explained:

> This was an error, and one I cannot explain, as I do not have a clear recollection of the assessment. I do not understand why I neglected to complete the boxes for [Yohan].

10.8 In evidence, Dr Elliott could not explain with any precision why he did not complete the relevant section of the Daily Sheet regarding the need for Yohan to be reviewed by a psychiatrist in four weeks' time, despite documenting the same in the progress notes. Whilst such documentation is of clinical importance to provide other clinicians with an understanding of a patient's clinical course, and the severity of a patient's condition at a particular point in time, it serves no administrative function in ensuring that the requisite booking for a follow-up appointment is made on PAS.

10.9 Instead, Dr Elliott could only surmise that he did not complete the relevant Daily Sheet entry for Yohan because his attention may have been diverted by an ad hoc enquiry. Dr Elliott explained that as he was reviewing patients alone on 24 December 2015, there were a number of persons eager to gain his attention throughout the course of the day, and that in the course of this daily practice he may have become distracted from completing the Daily Sheet entry for Yohan.

Changes since December 2015

10.10 Between January 2016 and October 2020, a number of changes have been made regarding processes within the Darcy Unit:

(a) Further education has been provided to staff at the MRRC in relation to the use of PAS, and the particular the PAS waitlist and appointment booking function;

(b) If, following review, a psychiatrist recommends that a patient be followed up by another clinician, this recommendation must be documented in the Diary, as well as on the electronic medical record system;

(c) Up until October 2020, the relevant entry from the Diary is scanned and faxed to the Custodial Mental Health Administration team (**the CMHA team**) at the conclusion of each shift;

(d) An entry is created by the CMHA team in PAS in relation to any requested follow-up appointment;

(e) Weekly audits are provided by the PAS Quality Coordinator on overdue PAS waitlist appointments, which are provided to Unit Managers for action.

10.11 In October 2020 a further change was made by Justice Health with the introduction of the Darcy Daily Clinic Tracker Sheet (**the Tracker Sheet**). This is used to assist with the handover of both clinical information and information about the recommended timing for mental health nursing and psychiatrist reviews. The Tracker Sheet, which is to be completed by psychiatrists working within Darcy Unit at the time of patient review, has a number of relevant features:

(a) It contains a number of prompts as to whether follow-up appointments are required with either mental health nurses and/or psychiatrists;

(b) It provides for a timeframe (in weeks) in which a follow-up appointment is required, if at all;

(c) It provides for notes to be made in respect of handover, together with comments for PAS;

(d) It includes a number of yes/no responses as to whether a patient requires:

(i) referral to the Mental Health Screening Unit or other accommodation;
(ii) is clear to return to the main prison population; or
(iii) specialist placement.

(e) It contains prompts to record the appropriate cell placement for each patient.

10.12 Prior to the impact of the COVID-19 pandemic, and associated restrictions, the Tracker Sheet was sent to the Darcy Unit Coordinator. Upon receipt, the Tracker Sheet is actioned by the administrative support team and saved in a secure electronic network storage system.

10.13 The Tracker Sheet is divided into a number of columns for each patient to be reviewed. The columns are divided to identify whether any follow-up review by a mental health nurse or psychiatrist is required, the timeframe for such a review, and for information to be included on PAS. Additional columns are also included to convey any handover information, and any additional comments to be recorded on PAS.

10.14 As at the date of the inquest, the Justice Health Custodial Mental Health Operations Manual (**the CMHO Manual**) had not been updated to reflect that the Tracker Sheet is now used within the Darcy Unit. Dr Sarah-Jane Spencer, Clinical Director, Custodial Mental Health and Co-Director (Clinical) Services and Programs for Justice Health, gave evidence that the absence of such updating has been due to resourcing constraints and added pressures relating to the impact of the COVID-19 pandemic. However, Dr Spencer gave further evidence that there are plans by Justice Health to update the CMHO Manual accordingly "*in the new year*".

10.15 Since the introduction of the Tracker Sheet, quarterly audits have been conducted to cross-reference and check the accuracy of information recorded in Tracker Sheets with corresponding entries in PAS. The most recent audit, conducted in August 2021, indicated that all patients who had a recommendation for review by a mental health nurse or psychiatrist, as recorded on a Tracker Sheet, also had a PAS waiting-list entry to accurately reflect this recommendation.

10.16 Dr Elliott gave evidence that he had not been provided with any formal training regarding the use of the Tracker Sheet. However, he indicated that the Acting Nursing Unit Manager had informally introduced the Tracker Sheet and explained its use. Further, Dr Elliott explained that the Tracker Sheet is "*rather self-evident*", and is both easier to use and more prescriptive than the previous Daily Sheet. Ultimately, Dr Elliott gave evidence that he felt comfortable using the new Tracker Sheet.

10.17 **CONCLUSION:** Dr Elliott made the frank concession that a record-keeping error on his part resulted in no booking being made for an intended psychiatric review of Yohan. Had such a booking been made, it is likely it would have been made for on or about 21 January 2016, two days before Yohan was found unresponsive in his cell. However, it is not possible to say how Yohan might have presented at any such review, or whether his presentation might have resulted in any change to his cell placement, or for the need for any treatment to be provided to him.

10.18 Since January 2016, a number of changes have been introduced by Justice Health regarding the manner in which follow-up appointments are made for inmate patients. Relevantly, the introduction of the Tracker Sheet means that a more robust system now exists which ensures that such appointments are clearly documented and booked on PAS. Although it appears that Justice Health has not provided any formal training to clinical and administrative staff regarding use of the Tracker Sheet, the evidence establishes that ihe Tracker Sheet is both easy to understand and use. Indeed, the results of a number of quarterly audits indicate that the Tracker Sheet has been appropriately used by both clinical and administrative Justice Health staff.

Review on 3 January 2016

10.19 PAS records confirm that Yohan was reviewed by RN Guilfoyle on 3 January 2016 at the MRRC Outreach Clinic. However, there is very limited information regarding the nature of this review, what information was available to RN Guilfoyle at the time of the review, and whether any further action was initiated by RN Guilfoyle. In response to a request for further information regarding the events of 3 January 2016, RN Guilfoyle provided a statement which indicates the following:

> The appointment list indicates [Yohan] presented to the MRRC Outreach Clinic on 3 January 2016 in relation to a recent assault-paranoid [sic]. Unfortunately I have no recollection of having seen this patient, on 3 January 2016. I also have had access to Volume 3 of his file and that hasn't triggered any memories of seeing him on this date.

10.20 The above statement represents the entirety of what is known regarding RN Guilfoyle's interaction of Yohan on 3 January 2016. Therefore, it is not known whether RN Guilfoyle had regard to any information contained in the progress notes for Yohan, and in particular to Dr Elliott's entry of 24 December 2016 in which reference was made to the need for Yohan to be reviewed by a psychiatrist in 4 weeks.

10.21 It should be noted that in January 2019 Justice Health updated its policy and guidelines in relation to accurate and comprehensive record-keeping in relation to all inmate patients receiving healthcare. Furthermore, Justice Health published a policy document (*Implementation Guide to NSW Health PD2012_069 Health Care Records - Documentation and Management and PD209_057 Records Management - Department of Health*) to provide guidance to all staff in relation to good record-keeping practices, and in particular the implementation of the NSW Health policies referred to above.

10.22 **CONCLUSION:** Regrettably, in the absence of any contemporaneous record, it is not possible to reach any conclusion regarding the nature of Yohan's presentation on 3 January 2016, and whether it was appropriate to initiate any treatment or action in response to his presentation. More particularly, it is not clear whether RN Guilfoyle might have had regard to the progress note entry by Dr Elliott regarding the need for Yohan to be reviewed by a psychiatrist, and recognised that a corresponding booking for such an appointment had not been made on PAS.

10.23 Since January 2016, Justice Health has published a policy document which provides guidance to its staff regarding the need for accurate and comprehensive record-keeping to ensure that reviews of inmate patients, such as the one that occurred with Johan on 3 January 2016, are properly documented.

11. Minimisation of potential ligature points

11.1 The inquest also examined aspects of cell architecture within correctional centres more broadly, and within the MSPC in particular. Information provided by CSNSW indicates the following:

(a) From at least February 2010, CSNSW conducted an audit of correctional centres and court cell complexes to identify cells that may be used for "a stepdown" following a period of acute suicide risk, followed by a prioritise program of capital works to eliminate obvious ligature points within accommodation areas for inmates on stepdown regimes. As at February 2019 there were 24 assessment cells and three stepdown cells utilise at the MSPC.

(b) Whilst correctional centres constructed after 2004 have been constructed with obvious potential ligature points being removed, difficulties have been encountered with correctional centres constructed prior to 2004 due to some centres being heritage listed. Both Long Bay Correctional Complex and the MSPC fall into the latter category. Accordingly, CSNSW has been

limited in making any substantial changes to reduce obvious ligature points, as this would require a major upgrade in both design and layout.

(c) By a letter dated 26 November 2021, the Governor of the MSPC indicated that through the prison bed capacity program two wings at the MSPC have been upgraded, with the upgrade involving the installation of Perspex sheeting on windows to cover bars in each cell, with coverings placed over potential ligature points on the walls of each cell. It is noted that neither of these wings are the wing where Yohan was found.

(d) Further, on 26 October 2021 the Acting Commissioner approved a submission for a strategy to prioritise capital funds of $6 million allocated for cell safety works to reduce the risk of inmates self-harming using ligature points in cells. The capital works prioritisation strategy is divided into five stages:

(i) Stage I involves the creation of a risk matrix to identify and prioritise cells from highest risk to lowest risk to inmates, together with completion of a risk assessment report to identify and prioritise cells with potential ligature points for refurbishment.
(ii) Stages II to IV involve site audits to analyse and prioritise the proposed works.
(iii) Stage V involves commencing recommended works based upon priority.

In addition, the Acting Commissioner has also proved the preparation of a briefing note for a business case to seek additional funding in excess of the current improved $6 million to complete the remaining identified scope of works.

11.2 Terry Murrell, General Manager, State Wide Operations, CSNSW Custodial Corrections Branch, gave evidence that it is not presently known whether the MSPC will be included on the list of correctional centres that will form part of the creation of a risk matrix as set out above. However, Mr Murrell indicated that as older will buildings in correctional centres are considered to pose the most risk, he expected that a correctional centre such as the MSPC would be high on the risk matrix.

11.3 **CONCLUSION:** The available evidence indicates that whilst CSNSW have, over many years, previously recognised the need to modify cell architecture in correctional centres in order to eliminate obvious ligature points, there have been a number of practical difficulties associated with implementation of such modifications. Relevantly, the fact that some correctional centres are heritage-listed has limited the extent to which necessary upgrades to cell architecture design and layout can be made. Therefore, the recent approval of a strategy to prioritise capital funds for cell safety works to reduce the risk of an inmate self-harming by using an available ligature point represents a significant improvement to inmate safety.

11.4 One additional issue which arose for consideration concerned the placement of Yohan in a one-out cell. Following his review on 24 December 2015, Dr Elliott cleared Yohan for a return to the main prison population for normal cell placement. Dr Elliott described the Darcy Unit as a "*noxious environment*" that is loud, where it is difficult to rest and sleep, and houses inmates recently admitted into custody who may be experiencing withdrawal from alcohol and other drugs. In

Yohan's case, Dr Elliott explained that transferring Yohan out of Darcy Unit into the main population would have provided a calmer environment for him.

11.5 The determination of what type of cell (one-out or two-out) Johan was to be housed in was not a matter for Justice Health but, rather, a matter for CSNSW. Mr Murrell gave evidence that upon receiving clearance from Justice Health that an inmate is suitable for normal cell placement, CSNSW reviews that inmate's record for any relevant alerts in order to identify whether the safety of other inmates might be affected by a particular cell placement. In Yohan's case, Mr Murrell noted that because Yohan previously had a number of disciplinary issues, and because some inmates had expressed fears for their safety regarding Yohan, a determination was made for Yohan to be placed in a one-out cell.

11.6 Dr Elliott explained that the issue of whether one-out cell placement might increase the risk of self-harm is a "*vexed question*". Relevantly, Dr Elliott referred to there being "*mixed evidence*" as to how effective two-out cell placement is in preventing self-harm. Further, Dr Elliott noted that mandatory two-out cell placement may cause disharmony amongst inmates, and that an inmate who is deemed to require a two-out cell placement may be viewed by other inmates as a burden, with associated stigma attached to such a view.

11.7 Further, Dr Elliott noted the following from his review of Yohan on 24 December 2015:

> With regards [Yohan's] risk of self-harm or suicide, his presentation was an extremely common one for the Darcy psychiatric clinic. He was a young offender with some custodial experience in Juvenile Justice facilities, a mental health history, and an extensive substance use history commencing in early adolescence and continuing up to the point of incarceration. He expressed anxiety about his charges and this was evident on mental state examination, but he denied a history of self-harming behaviour and he denied thoughts of self-harm or suicide around the time of the assessment. He did not appear pervasively depressed and there was no evidence of psychotic symptoms. I did not consider he represented a significant risk of self-harm […]

11.8 **CONCLUSION:** The available evidence indicates that the decision to place Yohan in a one-out cell was consistent with Dr Elliott's determination that he was suitable for normal cell placement. Further, it appears that this decision was reasonable as fears expressed by other inmates regarding Yohan's alleged anti-social behaviour needed to be properly considered. However, given the opinion expressed by Dr Elliott as to whether Yohan was at significant risk of self-harm, and the limited evidence regarding the effectiveness of two-out cell placement in preventing self-harm, it is not possible, to reach any conclusion as to whether a two-out cell placement might have had any impact on the eventual outcome.

12. Is it necessary or desirable to make any recommendations?

12.1 One issue which arose for particular consideration regarding the necessity or desirability of making a recommendation pursuant to section 82 of the Act concerned the Tracker Sheet. It was submitted by both the Coronial Advocate Assisting, and the solicitor for Yohan's family, that a recommendation should be made for the CMHO Manual to be updated to reflect that the Tracker Sheet is now to be used within the Darcy Unit. Conversely, it was submitted on behalf of Justice Health that such a recommendation is neither necessary or desirable given that the absence of an

update to the CMHO Manual is understandable having regard to the impact of the COVID-19 pandemic, that there is an intention by Justice Health to update the CMHO Manual "*in the new year*", and that a procedure has been adopted for use of the Tracker Sheet since October 2020, which has been subject to multiple audits.

12.2 **CONCLUSION:** It is accepted that the evidence establishes that the Tracker Sheet has already been in use since October 2020, with quarterly audits demonstrating compliance by Justice Health staff regarding its use. Further, it is also accepted that the impact of the COVID-19 pandemic has required the prioritisation of limited resources and their diversion elsewhere. Notwithstanding, 14 months have now passed since the introduction of the Tracker Sheet without the CMHO Manual being updated accordingly. Further, there is no precise evidence available as to a date by which the CMHO Manual might be the subject of a formal review, or as to when the CMHO Manual might be updated other than by a vague reference to such an update occurring sometime "*in the new year*". Therefore, it is desirable to make the following recommendation.

12.3 **RECOMMENDATION:** I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network, that the Custodial Mental Health Operations Manual be updated to reflect the introduction and use of the Darcy Daily Clinic Tracker Sheet.

13. Findings pursuant to section 81(1), Coroners Act 2009

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Ms Tina Xanthos, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Detective Inspector Ben Johnson for his role in the police investigation and for compiling the initial brief of evidence.

12.4 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Yohan Wepitiya-Gamage

Date of death

Yohan died on 22 or 23 January 2016.

Place of death

Yohan died at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036.

Cause of death

The cause of Yohan's death was hanging.

Manner of death

Yohan died, whilst in lawful custody, as a result of actions taken by him with the intention of ending his life.

19.1 On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Yohan's mother and sisters, his extended family and his many friends and loved ones for their tragic loss.

19.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
9 December 2021
Coroners Court of New South Wales

Inquest into the death of Yohan Wepitiya-Gamage

File Number: 2016/24535

Annexure A

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), the following material contained within Exhibit 1 is not to be published:

1. The names, addresses, phone numbers and other personal information that might identify any member of Yohan Wepitiya-Gamage's family.

2. The Corrective Services New South Wales (**CSNSW**) Investigation report and attachments in Exhibit 1 (Volume 1: TAB 14 of the brief of evidence).

3. The following CSNSW policies and documents found in Exhibit 1 (Volume 1: TABs 15 and 16 of the brief of evidence):

   (a) The Operations Procedure Manual (**OPM**) '*Section 13.3 RIT Protocols for the Management of Inmates at Risk of Self Harm or Suicide'* (2015);

   (b) OPM *'Section 13.3.2 Management of inmates at risk of suicide or self-harm in correctional centres'* (2017);

   (c) Commissioner's Memorandum 2010/03 *'Correctional Centre and Court Cells Audit for identification of 'High-Risk' Cell furniture installation and identification of obvious hanging points within cells'* which has not been made publicly available; and

   (d) Assistant Commissioner's Memorandum Custodial Corrections No. 2017/05 *'Revision of Operations Procedures Manual 13.3 RIT Protocols for the Management of Inmates at Risk of Self Harm and Suicide'* which has not been made publicly available.

Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until those parties have had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
9 December 2021
Coroners Court of New South Wales