CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr WW
Hearing dates:	4 July 2022
Date of findings:	4 July 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody
File number:	2021/00263382
Representation:	Counsel Assisting the Coroner, Mr Jake Harris, instructed by the Crown Solicitors Office
Findings:	I make the following findings in relation to the death of Mr WW, pursuant to s81 of the Coroners Act 2009 NSW: Identity: The identity of the deceased is Mr WW Date: The date of death of Mr WW was 14 September 2021 Place: The place of death was Kariong NSW Cause of death - the cause of death was in keeping with hanging Manner of death - the manner of death was suicide
Recommendations	Nil

Non-publication orders:

1. That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):
    a. CCTV footage and any stills of that footage;
    b. The Daily Schedule dated 14 September 2021;
    c. The names, master index numbers ('MINs') and other identifying information of inmates other than the deceased;
    d. The direct contact details of CSNSW staff and staff from external service providers that are not publicly available;
    e. The names, addresses and other personal information that identify or may identify the family and associates of the deceased or other inmates;
    f. The e-learning module titled 'Awareness of managing at risk inmates;'
    g. Portions of the following Custodial Operations Policy and Procedures (COPP):
        i. COPP 5.5 Cell security and alarm calls;
        ii. COPP 13.3 Death in custody; and
        iii. COPP 13.8 Crime scene preservation;

    in accordance with the schedule attached ('Annexure A').
2. Pursuant to section 65(4) of the *Coroners Act 2009* (NSW), a notation be placed on the Court file that if an application is made under section 65(2) of that Act for access to Corrective Services NSW documents on the Court file, that material shall not be provided until Corrective Services NSW has had an opportunity to make submissions in respect of that application.

3. Pursuant to s75 of the Coroners Act 2009 a non-publication order is made that the name of the deceased and his family members not be published.

JUDGMENT

Introduction

1 An Inquest was held into the death of Mr WW, who died at Kariong Correctional Centre on 14 September 2021. He was 48 years of age. Because Mr WW died while in custody, an inquest is required by the Coroners Act 2009 NSW (the Act).

2 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

3 I would like to commence these Reasons for Decision by expressing my sincere condolences to the family members of Mr WW for their loss. Mr WW is survived by his mother, VM, and his twin sister, CM, and brother, RM.

4 Mr WW was arrested on 12 September 2021 and charged with offences of contravening an Apprehended Violence Order. He was bail refused by police and remanded in custody. He was transferred from the police custody to Kariong Correctional Centre ("Kariong") on 13 September 2021. The following afternoon, at about 3.15pm, Mr WW appeared by video link before Toronto Local Court for an application for release to bail. He was refused bail by the Court. Mr WW was escorted back to his cell at around 4pm. Tragically, at about 5.30pm, Correctional Officers discovered Mr WW hanging in his cell.

The Coroner's role

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. A

Coroner's findings must not indicate, or in any way suggest, that an offence has been committed by any person (subsection 81(3) of the Act).

6 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death.

7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

Evidence

8 Prior to holding an inquest a detailed coronial investigation is undertaken. Investigating police compile a brief of evidence and a number of documents are obtained; including a report by a forensic pathologist as to the cause of death. Given that Mr WW's death occurred in a correctional facility, it was actively and thoroughly investigated by police, who obtained all correctional centre records, including medical records and incident reports, and CCTV footage from the centre. The police also interviewed various witnesses including correctional officers, arresting police, and family members, and witness statements are contained in the brief of evidence, and will be referred to in these Reasons for Decision.

9 Given the thoroughness of the coronial investigation, the detailed police brief provided evidence which answered a number of matters which the inquest was required to address. For this reason the only witness required to give

evidence at the inquest hearing was the officer-in-charge of the investigation, Plain Clothes Senior Constable Jesse Mears.

10 The Coronial investigation also obtained all relevant policy documents relating to management of inmates in correctional facilities to ascertain that the policies were complied with, and so as to consider whether any recommendations for change should be made.

Background

11 Mr WW was born on 2 November 1972, to VM and NM. VM has provided a statement to police about Mr WW. She says that Mr WW had been close to his father, who died in 2011. Mr WW had a twin sister, CM, an older brother, RM. VM, CM and RM attended the inquest via a video link from Toronto Local Court.

12 Mr WW was married to LW when he was younger, but it is believed she returned to New Zealand and may herself be deceased. Mr WW did not have children of his own.

13 Mr WW grew up in Argenton and went to Glendale High School. He became a fencer by trade and was working as a fencer at the time of his death. He also worked on commercial fishing boats, but he developed an allergy to fish. The evidence indicates that throughout his life Mr WW was regularly employed and was a hard worker.

14 In 2019, Mr WW and his then girlfriend, Alison, were living with VM at her house at Edgeworth. VM now believes that they were probably both using drugs at that time.

15 There is evidence in the brief that Mr WW took drugs, including methylamphetamine (ICE) and cannabis. Mr WW admitting to using those drugs when he was in custody in 2006. He also told his supervising officer from Lake Macquarie Community Corrections, on 13 July 2021, that he was

under the influence of ICE during the occurrence of the offences for which he was being supervised (pursuant to an Intensive Corrections Order).

16 It is also noted that both cannabis and methylamphetamine were detected in the toxicological examination conducted after his death, indicating he was using substances at some time before his death, (the amounts detected had no contribution to the cause of death).

17 From about October 2020, Mr WW was living on his own in a garage at VM's house. His brother RM, and cousin WWD, also lived on the premises.

18 VM reported to police that Mr WW suffered from poor mental health. VM told police that, when he was living with her, he was crying a lot and kept mainly to himself. She had worked as a nurse, and she thought he was depressed. On 8 January 2021, she took him to see Dr Gibbs at Cardiff General Practice. Dr Gibbs prescribed Pristiq, an anti-depressant, which Mr WW took for a few weeks, although VM believes he stopped taking it.

19 VM states Mr WW had never tried to take his own life in the past nor, to her knowledge, had he ever felt suicidal. However, reportedly there was a family history of mental health issues, including Mr WW's grandfather, who committed suicide.

Criminal History

20 As Mr WW died in custody, it is relevant to report his history of criminal offending. Between November 1990 and December 1995 he was charged with stealing, driving and drug-related offences. The 1990 offence of stealing was dealt with under a good behaviour bond (s558 recognizance), in 1990 there was a 100-hour community service order imposed for a minor dishonesty offence; and a number of the early minor drug offences were dealt with by non-conviction recognizances (under the former s556A) in 1996; a 2003 offence of contravene Apprehended Violence Order (AVO) resulted in the imposition a good behaviour bond; in 2006 he was convicted of firearm offences and common assault and imprisoned for 9 months. There is no

recorded offending from 2006 until 2021, when he was sentenced to an Intensive Corrections Order (see below).

21 VM states that Mr WW was subject to AVOs to protect family members – there was an AVO taken out against Mr WW to protect his sister, CM; and in 2019 an AVO was made to protect VM, at the time when Mr WW and Alison were living in her home.

22 On 2 February 2021, an AVO was made subjecting Mr WW to conditions to protect Alison. The AVO included a condition not to contact Alison in any way, unless through a lawyer.

23 On 2 June 2021, Mr WW was convicted of contravening that AVO, and of a separate offence of Stalk/intimidate– a note of discussions between Mr WW and the supervising community corrections officer about these offences is contained in the brief of evidence (at tab 34, page 4).

24 On 10 August 2021, Mr WW was sentenced to a 12 month sentence of imprisonment but this was directed to be served in the community on an Intensive Correction Order (ICO). The ICO was an aggregate sentence for two sets of offences – the first set contained charges of stalk/intimidate and breach AVO; the second set of charges involved a charge of stalk/intimidate and three breaches of AVO. The ICO required supervision by the Office of Community Corrections and contained further additional conditions – these included electronic monitoring (wearing a bracelet/tag), abstinence from drugs, a place restriction condition imposing an exclusion zone (Cardiff), and 90 hours' community service work. It appears the electronic monitoring may have been to enforce the place restriction which was intended to restrict Mr WW's ability to go near the person protected by the AVO. That sentence, of ICO, was still being served in the community at the time that Mr WW was arrested on the new charges, on 12 September 2021.

Arrest

25 On 12 September 2021 at about 7.14 p.m., Senior Constable Woods and Probationary Constable Mitchell Ronan attended VM's home in Edgeworth to arrest Mr WW for three breaches of the AVO. The dates of the alleged breaches of the AVO were: (i) between 28 and 31 August 2021; (ii) 6 September 2021; (iii) 7 September 2021.

26 The arrest was captured on the Body Worn Video by Senior Constable Woods. After Mr WW was cautioned by police, he told them that he did not send the emails. He stated that he believed his brother, RM, had sent them, who he told police had access to his email account. That Mr WW told police this is confirmed in the statement of Probationary Constable Ronan, and is also recorded on the Body Worn footage recorded at the time of the arrest.

27 The new charges, being the alleged breaches of the AVO, related to emails that had been sent from Mr WW's email address to Alison. An account of the emails was read to Mr WW, by Senior Constable Woods at the time of the arrest, and is recorded in the Body Worn Footage. The emails are alleged to have contained statements, sent from Mr WW's email account, to Alison's email, stating that "everyone keeps me informed on you", and that she had "taken enough from me, now I'll take from you; and also are said to have stated that Alison was dealing drugs, and that she was going to go to prison.

28 Mr WW presents in the body worn footage as calm when he is told of the emails, and he told police very clearly of his belief that the emails were sent by his brother.

29 After Mr WW was searched and secured in the police van, Senior Constable Woods spoke with Mr WW's brother, RM, this is recorded on the body worn footage. RM volunteered the information that he had sent a text message to Alison 'a few days ago' as he was upset for a friend, he said he did not have her number so used Mr WW's phone to send the text. RM also told SC Woods that he had been mentally unwell recently. He was unable to recall the specifics of what he said in the text message or when he sent it. RM told

SC Woods it was a recently sent text message. When questioned as to whether he sent any emails, RM said he had not sent any emails.

30 It was also alleged, as detailed in the notes of his supervising officer at community corrections, that Mr WW had entered Cardiff, in breach of the place restriction (exclusion zone) imposed by his ICO, on two occasions being 22 August and 2 September 2021. Community Corrections informed Mr WW that action would be taken if there were any further breaches of the exclusion zone. There were allegedly further breaches of the ICO although no action appears to have been taken by the time of his arrest. It was confirmed to the inquest, by the Officer in charge Plain Clothed Senior Constable Mears, that no warrant appears to have been issued for any breach of the ICO at the time of Mr WW's arrest on the new charges.

31 Senior Constable Woods said in his statement that he thought Mr WW appeared frustrated about being arrested, but he was otherwise calm and compliant. It appeared that Mr WW may have had some understanding, that he may be going to be arrested, as he told Senior Constable Woods that he had been intending to hand himself in the following day.

32 Mr WW was searched, placed in the police van and taken to Waratah police station.

Comments made to WWD

33 One issue which was explored in the coronial investigation and inquest was whether Mr WW made certain comments at the time of his arrest. VM believed Mr WW had made comments which were reported to her by WWD. VM was at home in her bedroom when Mr WW was arrested, although she did not speak with police. Mr WW's cousin, WWD, informed her that Mr WW had been arrested, and that Mr WW had said, "if they lock me up, you'll never see me again."

Mr WW's time in custody

Waratah Police Station

34 At about 7.45pm Mr WW arrived at Waratah Police Station. Senior Constable Woods completed a brief assessment and recorded in the Field Arrest Report that Mr WW had no injury, mental health issues, illness or pain, he did not want to self-harm and was not intoxicated.

35 Sergeant Brad Dawson, the Custody Manager, undertook a visual and brief assessment. He recorded answers to a list of standard questions, including that Mr WW had never tried to kill himself and did not have a mental illness. Mr WW was accepted into custody of the Custody Manager at 8.07pm.

36 From 8.50pm - 9.00pm, Sergeant Dawson completed the Bail Risk Assessment processes for the two charge numbers and determined that bail should be refused. Mr WW said he disputed the AVO breach allegations but accepted the bail decision and did not express threats of self-harm.

37 Mr WW also asked for access to his phone so he could close some share trades he was making, as he did not know how long he would be in custody. In fact, he kept some of those trades open. This conversation gave Sergeant Dawson the impression that Mr WW saw a future for himself at that time.

Newcastle Police Station/Newcastle Court Cells

38 Mr WW was then taken to Newcastle Police Station by Senior Constable Woods and transferred to the Newcastle Court Cells, in the custody of Corrective Services NSW (CSNSW).

39 A New Inmate Lodgement & Special Instruction Sheet was completed by Corrections Officer (CO) Forster. He also completed an Inmate Identification & Observation form, which recorded that Mr WW had never tried to hurt himself or end his life, felt 'ok' at the moment, and had no mental health issues for which he had been receiving treatment. It also recorded that Mr WW was not an alcoholic, a binge drinker or recreational drug user. The

'visual assessment for self-harm' section of the form recorded that Mr WW showed no signs of suicide or self-harm, did not show signs of agitation, aggression, depression or withdrawal, and had not made any threats of suicide or self-harm.

40 On 13 September 2021 no application for bail was made and the proceedings were adjourned to 14 September 2021 (presumably for a bail application). Mr WW was transferred to Kariong Correctional Centre at Gosford, arriving at 6.10pm on 13 September 2021.

Kariong Correctional Centre

41 Kariong is an Intake and Transit Centre, used to house inmates for limited periods before they are placed at Correctional Centres. There are 56 beds, with extra capacity where required.

42 At some time between his arrival and 8pm, Mr WW was seen by Justice Health Nurse Unit Manager (NUM) Elizabeth Mayberry. She administered a COVID screen, and a RAT test, which was negative. She also asked Mr WW about his mental health. He denied thoughts of self-harm, suicidal intent or harm to others, and denied any mental health concerns. He denied alcohol or drug issues. He voiced no concerns. She made a note about those matters in his health records.

43 Also, after his arrival at Kariong, Mr WW asked Correctional Officer ("CO") Kirsty Weatherburn to call his mother. He wanted to tell her where he was and that he loved her. Unfortunately, CO Weatherburn found the number Mr WW gave her had been disconnected. It is not known if this was conveyed to Mr WW or what his reaction was.

Cell placement

44 Mr WW was placed in Cell 26, on level 2 of Unit 3. It was a two-bed cell, but Mr WW was the sole occupant.

45 Corrective Services NSW policy regarding cell placement was obtained as part of the coronial investigation and was in the brief tendered to the inquest. It does not mandate that new inmates have be placed with a cell mate, although that is a cell placement option where, for example, a person is at risk of suicide or has special needs. Given the timing of this death, during the NSW Covid-19 lockdown, there was heightened concern about COVID transmission, especially in relation to newly received inmates.

46 Mr WW was not placed in temporary cell, such as a camera cell, which is an option for inmates who need to be monitored. Again, that is not mandated for new inmates. And on the information available nothing indicated Mr WW was at risk and would require monitoring in a camera cell.

47 Corrective Services NSW provides guidance which lists factors that may identify inmates who are at risk of self-harm, and training on managing suicide risk. That material does not include any factors relevant to Mr WW which might have alerted officers to a risk. No concerns were identified about Mr WW at the time he was received into custody.

48 In addition it was not made known that Mr WW had been using illicit substances at some prior time – he was on a current ICO which required abstinence so there was a reason for Mr WW not to disclose if he had been using recreational drugs prior to his entry to custody.

Events of 14 September 2021

49 At 9.23am the following morning, 14 September 2021, Mr WW activated his cell call alarm. This call was recorded, and there is a partial transcript in the brief. He asked if anyone knew what was happening with his case, as there was supposed to be a video hearing. The operator told Mr WW to ask one of the officers about this and assured him if there was a hearing they would come and get him.

50 Mr WW also repeated his concern that it was his brother who had sent the emails which had resulted in his arrest. He said:

> "Yep, just tell them I've got a mental case brother that ah has obviously jumped on my email and sent his friend an email from my site and I'm the one who's in the shit for it. Me brother's a mental, a mental problem and the mother will tell you that, ah I'm just copping the shit that's all."

51 On 14 September 2021 at 2.11pm Registered Nurse, Ashoo Fluit, attended Cell 26 with two officers to perform a "Fresh Custody Health Check". RN Fluit took Mr WW's temperature, which was normal, and undertook a welfare check. It is not known what questions were asked. RN Fluit recorded "nil other concerns voiced". That note was timed at 4.55pm, although the attendance was earlier.

52 At around 3.11pm CO Philip Nicholls collected Mr WW from his cell for a legal call with his solicitor, and escorted him with CO Michael Hall to the audio-visual unit. The officers reported that Mr WW seemed calm before and after this call.

53 After being returned to his cell, Mr WW was then taken again to the audio-visual unit to appear before Toronto Local Court. The video was not functioning, so the Court hearing was conducted using audio only. Mr WW was denied bail. He indicated a Not Guilty plea, and a hearing date was set for 11 March 2022. A call-over date was also set for 23 September 2021.

54 After the bail hearing, COs Nicholls and Hall released Mr WW from the video booth and CO Nicholls asked how the hearing had gone. Mr WW replied he had been bail refused until March. He appeared "very disappointed" about this. CO Nicholls told Mr WW that he would obtain the information when the paperwork came through from the court, including the exact remand date, in case Mr WW had misheard. Mr WW thanked him politely and was escorted back to Cell 26 at around 4.00 to 4.15 p.m.

55 That was the last interaction Mr WW had with anyone before his death. In the intervening time he was alone in Cell 26. CCTV footage outside the cell has been obtained. It confirms that no one else entered or exited.

56 CO Nicholls went to check the Corrective Services computer system and obtained Mr WW's next Court date, which he intended to tell to Mr WW when he saw him next.

Mr WW's death

57 At just before 5.30pm, COs Nicholls, James Green and Paul Villata were distributing meals to inmates. CO Nicholls approached the door of Cell 26 and called out that he had information for Mr WW. He opened the door and saw Mr WW partially suspended from the top bunk by his gaol-issued 'sloppy jo' jumper. The jumper had been tied into a loop, and a jogger had been wedged behind the guard at the corner of the top bunk as an anchor point.

58 CO Green called a Medical Emergency Response on the two-way radio and the three COs lowered Mr WW to the ground, rolled him onto his back and started CPR. COs Nicholls and Green noted Mr WW was very cold and they could not find a pulse. RN Fluit arrived at approximately 5.34 p.m. CPR was continued until the paramedics arrived and took over, at about 5.47pm. Resuscitation efforts continued for a further 40 minutes.

59 Tragically Mr WW's death was declared by paramedic Allan McKinlay at 6.40p.m.

60 A post-mortem examination was conducted by Dr Donovan Loots on 16 September 2021. The direct cause of death was stated to be 'in keeping with hanging'. No antecedent causes or other significant contributing conditions are identified.

61 Toxicology detected non-toxic levels of methylamphetamine and cannabis metabolites, but no alcohol. There is no evidence indicating that those substances contributed to the death.

Investigations and changes made

62 Corrective Services NSW undertook a Death in Custody investigation into Mr WW's death. A report was prepared by Principal Investigator Paul Sheehan, who attended Kariong on the morning of 15 September 2021. In Mr Sheehan's view, Mr WW's management complied with Corrective Services NSW policies. He stated:

> "[t]here is no evidence or information that Mr WW displayed any indication of being at risk or self-harm when he was last seen alive."

63 Justice Health and Forensic Mental Health Network (the Network) undertook a Serious Adverse Event Review following Mr WW's death. In correspondence with the coronial investigation the Network has identified improvements that have been made at Kariong and elsewhere.

64 Since Mr WW's death, the nursing shift patterns at Kariong have been reconfigured. Nurses are now available in the afternoon shifts 7 days a week, to screen inmates who arrive late in the day, as Mr WW did.

65 The Network has also introduced an initiative called "Towards Zero Suicides in Care". This commenced in 2020 and will continue during the current and following financial year. A Position Paper was provided to the coronial investigation and added to the brief of evidence. Priority areas relevant to Mr WW's case include training for staff at all levels, on suicide prevention, including Corrective Services staff where appropriate, and the need to collaborate with agencies including Corrective Services to identify and manage patients' suicidal thoughts and behaviours.

66 Notably, the Position Paper recognises that:

> "statistically a death by suicide is more likely to occur while a patient is on remand and therefore consistent and appropriate screening should be undertaken at reception and during the early stages of care to gain an understanding of the patient's personality history and experience with suicidal thoughts and behaviours."

67 In addition, as discussed below, there is a recommendation that possible correlation between outcomes of court proceedings for those on remand/in custody, and self harm, be examined. This initiative may be particularly relevant in identifying risk of self harm in people such as Mr WW, given that the timing of his death appears linked to the court outcome which occurred shortly before (whereby Mr WW was refused bail).

Findings

68 There is no evidence to support a finding that Mr WW said the words alleged by WWD at the time of his arrest. The words cannot be heard on the Body Worn Video footage. The importance of determining this issue is that this was the sole report of anything said by Mr WW, around this time, which might indicate a risk of self harm. All the custody screening processes indicated no risk, and Mr WW did not make any other statements indicating a risk of self harm, nor did he present as at risk.

69 However, even if the words were said, there is no evidence they were heard by police. Neither officer recalls it in their statement. The OIC confirmed during his evidence at the inquest that if police had heard Mr WW refer to self-harm, it would have been noted, and police would also have asked him about it at the time he was taken into custody. Any threat of self harm would have been noted in the custody screening questionnaires and records.

70 I do note that the body worn footage of the arrest (recorded on body worn camera of Senior Constable Woods) is consistent with the impression of the arresting officers, and the Sergeant at Waratah police station, that Mr WW did not present as distressed or with noticeable mental health stress and/or symptoms, nor otherwise present as at risk of self harm. During the body worn footage recorded at the time of the arrest, Mr WW appears calm, and is certainly co-operative. There is a discussion later during the arrest where Senior Constable Woods advises Mr WW that given the criminal history of breaches of AVO, and that he currently was on parole (a reference to the supervised ICO and the electronic monitoring) it was likely that the custody

sergeant would refuse him police bail so he would be detained and presented before the court. After this discussion about bail, Mr WW still appears calm in his presentation as recorded on the body worn footage.

71 Mr WW was asked about his welfare and mental health on several occasions during his short time in custody, as detailed above in these reasons for decision - there were 5 screening occasions, two at Waratah police station, one at Newcastle cells, two at Kariong, as detailed above. On each occasion, Mr WW denied mental health issues or thoughts of self-harm, and also did not report any use of recreational drugs.

72 There is no evidence that Mr WW presented to arresting police, or to police at Waratah police station; or to custodial officers at Newcastle cells, or to anyone at the Kariong Correctional Centre, as being at risk of harm or of being mentally ill or in emotional distress. There is no evidence on which a conclusion could be formed that those who saw Mr WW during his time in custody should have taken action to monitor him for self harm. There is no basis for concluding that any custodial officer, whether police or correctional officer, failed to act to ensure Mr WW's well being. There is also no basis for finding that applicable policies and procedures were not followed.

73 The evidence supports a conclusion that Mr WW formed a decision to end his life after his Court hearing on 14 September 2021. This may well have been impulsive, or perhaps he was concerned at the length of remand, or possibly the prospect of a possible gaol sentence if convicted of the new charges, [Given his record for prior similar offences and that he was at the time of the alleged new offences serving a sentence by way of ICO for offences against the same victim, this possibility of a gaol term if convicted may have been a possibility of which he was aware]. Given the timing of his actions were soon after a court appearance where he was refused bail by the court, there is an inference available that the prospect of remaining in custody contributed to his state of mind. However, it is not possible to know what other factors were at play. Mr WW gave no overt sign that he intended to harm himself. There is no evidence of Mr WW being troubled or expressing any suicidal intention. VM

has suggested that he may have been troubled over his relationship with Alison.

74 The evidence of the circumstances of his death, including the deliberate action of hanging himself when alone in a cell - with no prospect of being found and revived, and no real possibility of being interrupted - supports the finding that action to hang himself was intentional with intention to self harm.

75 On the basis of all the evidence, as detailed in above in these Reasons for Decision, the circumstances of Mr WW's death support a finding that the death was self-inflicted, with intention to end his life.

Changes made - whether recommendations for further changes are required

76 I note the changes made at Kariong as set out above in these Reasons for Decision, in terms of shift allocation of nurses which ensures more immediate screening of those in custody on reception.

77 I also observe that advice given to the inquest, by Justice Health, indicates that the 'Towards Zero Suicides in Care Initiative' will consider the issue of court appearances and whether this can present a risk of self harm by an inmate.

78 The advice stated as follows:

> Towards Zero Suicides in Care initiative has been funded through NSW Health since financial year 2020/21 to June 2022. Justice Health and Forensic Mental Health Network (the Network) has received confirmation that this funding will continue through FY 2022/23.
>
> The Network has employed a Senior Project Officer Towards Zero Suicides in Care to undertake the objects of the initiative.
>
> A Suicide Prevention Position Paper has been developed to address Recommendation 2 'The Network through the towards Zero suicide program review DIC [deaths in custody] and correlation to Court proceedings, develop a position paper and consider any improvements or recommendation for future practice'.

> The implementation of the Position Paper, recommendations and action plan will be coordinated through the Senior Project Officer Towards Zero Suicides in Care position.

79 A copy of the position paper was provided to the inquest. The position paper "The Health and Forensic Mental Health Network Position Paper: Suicide Prevention in Custody" states as follows:

> Overview
> The Network's patient population are vulnerable to suicidal thoughts and behaviours and death by suicide. Since 2012, 42 of the Network's patients have ended their life while in custody and many more have made attempts. These numbers reflect national and international research around the rate of suicidal thoughts and behaviours in correctional facilities as well as anecdotal feedback from those with lived experience of custody.
>
> "…I know I said that the thought goes through my head, like every other inmate in here…"
> …
> Reasons for higher rates of suicidal behaviour in custody are complex with individual distal, developmental and proximal risk factors overlapping and interacting with population and environmental risk factors. At the individual level, suicidogenic and criminogenic risk and protective factors overlap meaning that the factors that made a patient vulnerable to offending, may make them vulnerable to suicide. Distal and developmental suicide risk factors such as early life adversity, cognitive deficits, personality traits, high impulsive aggression, drug and alcohol misuse and serious mental health conditions are overrepresented in the custodial population. Being incarcerated is a life event that can lead to feelings of guilt, shame and isolation which can be experienced as a result of how the individual feels about the crime they committed, their victims or the punishment received. These risks are then exacerbated by the custodial environment which can negatively impact an individual's mood, social connections and sense of self, hope, purpose and control.
>
> The Suicide Death in NSW: 2012-2018 Snapshot (DG39810/22) found that patients had varying suicide risk factors, life events and presence and level of severity of mental health conditions. This finding highlighted the concept that custodial suicidal thoughts and behaviours are complex and dynamic and therefore multiple suicide prevention interventions are required to create a suicide safety net. This suggestion is supported by recommendations from Serious Adverse Event Reviews and Coronial Inquests that have encouraged the Network to take a systematic approach to the identification and ongoing management of patients vulnerable to suicidal thoughts and behaviours while in custody. In order to address the complexity and multi-dimensionality of suicide and the heterogeneity of the patient population and the resource available to the Network, the proposed strategy is focused on introducing and embedding practical and reasonable suicide prevention interventions at the primary, secondary and tertiary levels.

80 I note that the project “Towards Zero Suicides in Care” will consider any correlation between deaths in custody and court outcomes and consider improvements in future practice. I note that this inquest has received evidence suggesting that a trigger for Mr WW’s self harm may have been the result of his bail hearing. Given the focus of the Towards Zero project, and the commitment to the project indicated in the information provided by Justice Health, then I am satisfied that this issue is being examined with a view to recommending any changes which could prevent suicides in custody. I am therefore of the view that no recommendations are required to be made in this inquest.

Formal findings

81 I make the following formal findings under s81 of the Coroners Act.

Identity: The identity of the deceased is Mr WW

Date: The date of death of Mr WW was 14 September 2021

Place: The place of death was Kariong, NSW

Cause of death: The cause of death was in keeping with hanging

Manner of death: The manner of death was suicide

Closing

82 I acknowledge and express my gratitude to Counsel Assisting the Coroner, Mr Jake Harris, and the instructing solicitor from the Crown Solicitors Office, Ms Rebecca Campbell, for their assistance both before and during the inquest. I also thank the investigating Police Officers, and in particular the former Officer in Charge of the investigation, Detective Senior Constable Rodney D’Bras, and the current Officer in Charge of the investigation, Plain Clothes Senior

Constable Jesse Mears, for their work in the Police investigation and compiling the evidence for the inquest.

83 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Mr WW.

84 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

****

ANNEXURE A

1. COPP 5.5 Cell security and alarm calls
    a. Table 1, Section 2.2 on page 4
    b. The second paragraph on page 5
    c. Section 2.3, points 4 and 7, the text in the table under the heading ‘Procedure’ on page 5
    d. Section 2.4, points 6, 7, and 10, the text in the table under the heading ‘Procedure’ on page 6.
2. COPP 13.3 Death in custody
    a. Section 2.4, the third sentence, page 6
3. COPP 13.8 Crime scene preservation
    a. Section 4.1, paragraphs 1, 2 and 4 on page 10
    b. Section 4.1, points 1 to 4, the text in the table under the heading ‘Procedure’ on page 11.