CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of Mr Gavin Ellis
Hearing dates:	24-28 May 2021, 27 October 2021
Date of final submissions: **Date of findings:**	29 July 2022 2 September 2022
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-self-inflicted death in custody- mandatory inquest-adequacy of mental health care-Care Pathways Model for Custodial Mental Health; Renewed Model of Care an Implementation Plan-Waitlists for psychiatric review-Risk Intervention Team- Management in safe cells-Recording of knock up calls- Cell checks at night- ligature points
File number:	2017/99958
Representation:	Ms J Davidson, Counsel Assisting instructed by Ms C Healey-Nash, Crown Solicitors Office Mr D Evenden, instructed by Legal Aid NSW, representing Mrs Ellis (Mr Ellis's mother) Ms K Doust, instructed New South Wales Nursing and Midwives

	Association representing Registered Nurse Fahy and Registered Nurse Chibvongodze Ms R Graycar, instructed by Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Ms A Horvath, instructed by Makinson d'Apice Lawyers representing Justice Health and Forensic Mental Health Network
Findings:	I find that Mr Gavin Ellis died on 2 April 2017 at the Metropolitan Remand and Reception Centre, Silverwater Correctional Centre, Holker Street, Silverwater as a result of hanging. He died as a result of actions taken by him with the intention of ending his life.
Recommendations:	**To the Commissioner of Corrective Services New South Wales:** 1. I recommend allocating funding as a priority, to the removal of ligature points in all Darcy Unit cells at the MRRC; and 2. I recommend consideration be given to adding a requirement for additional random patrols of the Darcy cells in the roles and responsibilities of officers on the B watch at MRRC. **To the Commissioner of Corrective Services NSW and the Chief Executive Officer, Justice Health and Forensic Mental Health Network:** 1. I recommend that consideration be given to what steps could be made to deliver better support and care to inmates who are placed in safe cells, and to inmates who have

	recently been released from safe cells, including the provision of multidisciplinary services such as occupational therapists, social workers, and psychologists, in order to minimise the likelihood of deterioration of their mental health. **To the Chief Executive Officer, Justice Health and Forensic Mental Health Network:** 1. I recommend that further training and education be given to Justice Health staff in completing the Health Problem Notification Form in relation to inmates who have been subject to a RIT, for the purpose of assisting Corrective Services NSW offices identify relevant signs that may indicate risk of self-harm.

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the sad death of Mr Gavin Ellis who died overnight between 1 and 2 April 2017, while he was in custody at the Metropolitan Remand and Reception Centre at Silverwater (MRRC). He was only 31 years old. He was found hanging on the back window of his cell by a ligature made from bed sheets.

2. Mr Ellis had a longstanding psychotic illness and had attempted to hang himself twice during his first three days in custody. At the time of his death, he was in the Darcy Unit of the MRRC. Despite an identified risk of self-harm leading to a Risk Intervention Team (RIT) being put in place between 20 and 24 March, referral for psychiatric assessment, deterioration of his mental health, and complaints by him that his changed medication was not working he was not seen by any mental health clinician for eight days leading up to his death.

3. The Corners Act NSW 2009 requires a senior coroner to conduct an inquest where a death occurs in custody. In such cases the community has an expectation that the death will be properly and independently investigated.

4. This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. The primary focus in this

inquest is whether there are any lessons that can be learned from Mr Ellis' death, and whether anything should or could be done to prevent a similar death in the future.

5. Pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Background and Mr Ellis' mental health history

6. Mr Ellis was born in Australia on 6 June 1985. He was the much-loved son of Cheryl Ellis and sister to Peta Ellis. He grew up living with his mother and sister.

7. Mr Ellis' mother attended each day of this inquest, and her love of her son was evident.

8. In his parole records, Mr Ellis reported that he was diagnosed with attention deficit hyperactivity disorder, Tourette syndrome and obsessive-compulsive disorder as a young child. He struggled with learning difficulties throughout his schooling years. He completed year 10 but his learning difficulties meant that he did not complete subsequent TAFE courses. At around the age of 17 he was diagnosed with schizophrenia.

9. Mr Ellis reported drinking alcohol from the age of 16, which he described as binge-drinking and as having had a negative impact on his mental health. He reported that he had acquired a brain injury from alcohol abuse and falling while intoxicated.

10. Tragically, Mr Ellis also had an extensive and longstanding history of self-harm. His mother, Ms Cheryl Ellis reported that he first attempted suicide at the age of approximately 8 or 9 years old, with subsequent attempts during his high school years.

11. At the time of his death, Mr Ellis had three extended periods in custody: first, from 11 October 2015 to 24 March 2016; secondly, from 27 April 2016 to 26 January 2017; and then, from 14 February 2017 until his death on 2 April 2017.

11 October 2015 to 24 March 2016 in custody

12. During this first extended period in custody, custodial records disclose three instances of actual or threatened self-harm: 13 October 2015, 8 December 2015 and 9 or 10 January 2016,[1] multiple instances of threatened harm to others,[2] and various episodes of heightened anxiety, aggression, paranoia and psychosis, largely concerning the uncertainty of securing post-release accommodation.

13. Mr Ellis experienced significant difficulty in securing accommodation following his first period in custody, which extended his stay for two months beyond the earliest parole release date. Eventually, Mr Ellis found accommodation through Rainbow Lodge, and on 24 March 2016 he was released from custody on parole.

24 March 2016-27 April 2017 on release

14. During his time at Rainbow Lodge, Mr Ellis displayed significant mental health problems including auditory hallucinations, aggression, and extreme paranoia. It appears that these problems were exacerbated by alcohol use. On 4 April 2016 he was taken by Camperdown Mental Health and scheduled in Concord Hospital under the *Mental Health Act 2007*.

15. On 11 April 2016 Mr Ellis was provided accommodation at Matthew Talbot Hostel in Woolloomooloo. On 18 April 2016, he informed Community Corrections that he had been

[1] Exhibit 1 Volume 1 Tab 15.
[2] Exhibit 1 Volume 1 Tab 15

charged with two counts of assault, had begun drinking alcohol again, and had left Matthew Talbot Hostel for the Tweed Heads region.

27 April 2016-26 January 2017 in custody

16. On 27 April 2016, Mr Ellis was arrested in Lismore on charges of being armed with intent to commit indictable offence, resist officer in execution of duty, affray, destroy or damage property and intimidate police officer in execution of duty without actual bodily harm. He was taken into custody in the cells at Lismore Court, where he was observed acting aggressively.

17. His parole was revoked.

18. On 9 May 2016, Mr Ellis arrived at the MRRC.

19. During a mental health referral on 24 May 2016, Mr Ellis expressed his willingness to attend rehabilitation. He explained that while he was on parole, he had been drinking alcohol, using methylamphetamine and not complying with his mental health medication.

20. Mr Ellis appears to have been more settled during this second period in custody, but his mental health continued periodically to present issues. On 10 July 2016, he threatened to slash his throat and reported a desire to harm his cell mates. In an interview with a psychologist on 12 July 2016, he indicated that he expressed a desire to harm others as a means of securing a one-out cell placement.

21. Mr Ellis made numerous requests to attend alcohol and drug rehabilitation during his second extended period in custody and was offered a placement at the Dooralong Rehabilitation Facility from 27 January 2017.

26 January 2017-14 February 2017 on release

22. On 26 January 2017 he was released on parole. Shortly before release, he was reportedly told that he must not possess tobacco at Dooralong. On 27 January 2017, Mr Ellis did not arrive at Dooralong, and his parole was revoked.

23. On 31 January 2017 he rang Wyong Community Corrections and explained that he did not want to attend Dooralong because he would not be able to smoke there. He also informed Community Corrections that he was awaiting triage at St. Vincent's Hospital in Sydney as he was experiencing auditory hallucinations. Reports indicate that he left St. Vincent's of his own accord later that day.

14 February 2017-2 April 2017 in custody

24. On 13 February 2017, Mr Ellis was arrested in Surry Hills on charges of intimidate police officer in execution of duty without actual bodily harm, destroy or damage property, common assault (two charges) and robbery. The custody management record for Mr Ellis relating to the time of his arrest indicates that he was highly intoxicated, extremely aggressive and threatening, and had slammed his head into the dock door.[3] At 7:24 pm, Officer William Collins recorded that Mr Ellis "*attempted to wrap underpants around neck and hang himself. Clothes cut off to prevent any self-harm.*"[4]

25. On 14 February, a 'New Inmate Lodgement & Special Instruction Sheet' and an associated 'Inmate Identification & Observation Form', were completed indicating that Mr Ellis was at risk of self-harm or suicide.

---

[3] Exhibit 1 Tab 17
[4] Exhibit 1 Tab 17

26. On 15 February, a remand warrant was executed. The warrant stated, by way of additional information, that Mr Ellis was *"to be referred to Justice Health for psychiatric screening regarding issue of self-harm"*.[5] On 16 February, a 'Request for Court Report and/or Assessment' form was completed by officers of Corrective Services NSW seeking a referral of Mr Ellis to Justice Health for psychiatric screening for self-harm.

27. At approximately 9:40 am on 16 February, a nurse was called to Mr Ellis' cell in response to an apparent attempt at hanging. Mr Ellis had tied a t-shirt around his neck and secured it to the hatch. At this time he disclosed that his *"depo"* (medication taken to treat his schizophrenia) was overdue by one week and that he had not been compliant with his mental health medications since leaving custody.

28. Later that day, Mr Ellis was transferred to the MRRC. A 'Health Problem Notification Form' ("HPNF") noted that Mr Ellis had a history of problematic substance use, self-harm issues and mental health and behavioural problems. It stated that Corrective Services Officers need to place him in a camera assessment cell, one out, with limited possessions, no sharps and underwear only. On 17 February, a document named 'MRRC – RIT Management Plan' was completed and lists a review date of 19 February. A Case Note on the same date states *"[a]ttempted hanging – upset because he wanted a blanket"*.[6]

29. Although the Management Plan listed a review date of 19 February 2017, the review occurred on 20 February 2017. Following this review, the monitoring of Mr Ellis by the RIT was terminated, and he was placed in a normal cell and referred to a psychiatrist.[7]

30. A further HPNF, signed by two members of the RIT who reviewed Mr Ellis on 20 February 2017, stated that Corrective Services Officers needed to hold Mr Ellis in *"Darcy"* until a bed was available in *"Hamden 17/18"*, and that Mr Ellis had mental health issues and *"impulsive*

---

[5] Exhibit 1 Tab 16
[6] Exhibit 1 Tab 17
[7] Exhibit 1 Tab 15

self-harm". The HPNF further directed Corrective Services offices that Mr Ellis should be given a normal cell placement.

31. A 'Mandatory Notification for Offenders "At Risk" of Suicide or Self-Harm' form was also signed on 20 February. That document stated that *"[t]he Justice Health medical file, the case file, the psychology file etc were available at the meeting. This inmate is not currently at risk of self-harm or suicide"*.[8] It listed the changes that have lowered the risk of self-harm or suicide for Mr Ellis as: *"[g]uarantees safety; appears stable; future oriented."*[9]

32. Later the same day, Dr Sunny Wade, psychiatrist examined Mr Ellis. She formed the opinion that Mr Ellis had schizophrenia with underlying delusions and hallucinations, but no thought disorder or mood disturbances. He was noted to have a history of harm to himself and others when mentally unwell, requiring ongoing observation while in custody. He expressed motivation to continue medication and receive psychiatric follow up, and it was Dr Wade's opinion that he would benefit from support and monitoring in a custodial area with additional mental health support. The psychiatrist recommended that Mr Ellis commence a trial of aripiprazole depot after a trial of oral aripiprazole, that his dosage of quetiapine be increased to 400 mgs nocte and that he take 100 mgs of sertraline daily.

33. Dr Wade considered it was suitable to place Mr Ellis in a normal (two out) cell. She referred him to the Hamden Unit and requested a psychiatric follow up for two weeks' time. Dr Wade had no further involvement in Mr Ellis's clinical management.

34. On 21 February 2017, an 'Intake Screening Questionnaire' stated that Mr Ellis was *"cleared from RIT 20/02/2017"*, *"uses cannabis and ice – denies alcohol issues"* and had *"no current thoughts of self-harm or suicidal ideations"*.[10] It noted that Mr Ellis had three active

[8] Exhibit 1 Tab 17
[9] Exhibit 1 Tab 17
[10] Exhibit 1 Tab 17

self-harm alerts, described as *"Self-Harm Risk"*, *"History of Self Harm Incident"* and *"Self-Harm Actual"*.

35. On 24 February 2017, Mr Ellis was transferred to the Hamden Wing.

36. On 1 March 2017, a mental health nurse reviewed Mr Ellis and noted that he denied having auditory hallucinations since changing medications.[11] The priority given to a psychiatric review (which had been ordered by Dr Wade) was *"determined to be less urgent"*.

37. On 1 March 2017, a "priority 4" waitlist entry was made in Hamden for a mental health review appointment for Mr Ellis on 1 April 2017. "Priority 4" meant this was a routine appointment and meant that the patient must been seen within 6-12 months.

38. On 13 March 2017, Mr Ellis approached Peta Dean, a staff member at the MRRC, and informed her, that, *"he felt paranoid and like people were out to get him and that he really wants to go to rehab."*[12]

39. On 17 March 2017, Mr Ellis contacted his mother. During this conversation he told Ms Ellis that he was hearing voices and that it was making him sick in the head. Ms Ellis asked if he had seen the psychiatrist, and Mr Ellis stated that he needed to see a psychiatrist and did not know how he was going to do this sentence.[13]

40. On 20 March 2017, Mr Ellis was heard screaming from his cell that other inmates were going to get him and were calling him a paedophile. When approached by Stephen Taylor, a Corrective Services Officer, he threatened to slash his own throat if he were not moved from

[11] Exhibit 1 Tab 22
[12] Exhibit 1 Tab 15
[13] Exhibit 1 Tab 3

the area. Mr Ellis was subsequently placed in restraints and escorted to the holding cage while a safe cell was organised for him.

41. Mandatory notification forms completed following the incident noted that Mr Ellis was at risk of self-harm based on hearing voices and presenting as incoherent. As part of the immediate support plan developed for Mr Ellis, he was placed in a camera cell with underwear only, and placed on a RIT.

42. On 22 March 2017, Mr Ellis was reviewed by a RIT. A HPNF noted that Mr Ellis was to remain on a RIT due to threat of self-harm, in a one-out camera cell. The RIT Management Plan recorded that Mr Ellis had a history of self-harm by means of slashing. It was not recorded that he had also self-harmed by means of hanging, overdose and head butting. He was assessed as a medium level of risk to himself.[14] Case Notes taken by members of the RIT recorded that Mr Ellis was hearing voices, had no suicidal ideation and could guarantee his own safety, thought that his medication didn't work and wanted to see a psychiatrist for medication review. The team made a collective assessment that Mr Ellis was to remain on a RIT and in a one-out camera cell. The team were aware that he was on the waitlist to see psychiatrist.

43. On 24 March 2017, Mr Ellis was reviewed by a RIT. The HPNF completed at this review recorded that RIT was to be terminated, and that he was to be put in a one-out cell. The RIT Management Plan recorded that his risk of self-harm was now assessed as being low, although his risk to and from others remained at a medium level. The HPNF noted that Mr Ellis was awaiting transfer back to Hamden when a bed became available.

44. The Mandatory Notification form indicated that the changes giving rise to the lowered risk level were that Mr Ellis "*appears calm/stable; at present denies any self-harm ideation or*

[14] Exhibit 1 Tab 17

plan; guarantees his and others safety"[15]. Monitoring was said to be "as required", and the "Referral" section of the form noted referral to a psychiatrist.

45. Case Notes taken at the review refer to Mr Ellis reporting auditory hallucinations and being "genuinely paranoid and distracted and vigilant", but said that he had an insight into his mental health and didn't want to stay in the safe cell as it was not conducive to his "deteriorating mental health". The notes also say:

> *"Stated today he is not suicidal, however believes Dr prescribed him the incorrect medication. Reported he believes paliperidone injection is more suitable for his mental health.*
>
> *Report oral meds helping – Zoloft &* [unknown].
>
> *Future focussed ie parole hearing and "changed to protection" SMAP status.*
>
> ...
>
> *Denied harm to self & others. Able to aptly guarantee his safety, however reported he is excessively paranoid & fearful other inmates will assault him.*
>
> *One out cell placement due to paranoia. Very distracted and agitated during contact. Refer to psychiatrist.*
>
> *Terminate MNF as assessed as low risk of harm to self."*[16]

46. On 25 March 2017, Mr Ellis was given aripiprazole depot despite voicing reluctance to have the depot as he felt it was not working.

47. On 31 March 2017, during the evening medication round at approximately 8pm, there was an incident (which is recorded in Mr Ellis's medical chart as "aggressive behaviour during pill round, tried to get out"). Corrective Services officers who attended Mr Ellis's cell refer to

[15] Exhibit 1 Tab 17
[16] Exhibit 1 Tab 17

him suddenly pushing the door out hard, as though he was trying to get out of the cell. The CCTV of the incident shows it happening very quickly. Mr Ellis does not appear from the CCTV to have exited the door of his cell, because the officers pushed the door back. The Justice Health nurse who subsequently attended stated that he had no independent recollection of the incident and did not, at the time, make a separate clinical record of it or refer Mr Ellis to the psychiatrist.

2 April 2017

48. On 1 April 2017, at approximately 7:30 am, Mr Ellis attended a medication round prior to retirement to a one out cell placement. His presentation was recorded as being unremarkable.[17] At 9:18 am, Mr Ellis contacted his mother and telephone records suggest he appeared to be confused and disoriented.[18]

49. An appointment had been made for Mr Ellis for 1 April 2017 on the Hamden Unit waitlist for a mental health review. By this point, Mr Ellis was no longer in the Hamden Unit but was in the Darcy Unit, which had a separate waitlist, with inmates from Darcy not usually taken to Hamden for appointments. Unfortunately, Mr Ellis was not taken to his mental health review appointment on 1 April 2017 in the Hamden Unit.

50. Between approximately 6:30 and 7:00 pm on 1 April 2017 during medication rounds, Mr Ellis refused to accept his medication, quetiapine.

51. On 2 April 2017, at approximately 6.10 am, Mr Ellis was discovered by Corrective Officers hanging at the rear of his cell from a window, with a bed sheet wrapped around his neck. Several officers and nurses cut Mr Ellis down and attempted to revive him, however he was later declared deceased.

---

[17] Exhibit 1 Tab 3
[18] Exhibit 1 Tab 3

52. The autopsy report determined that Mr Ellis died by hanging. Toxicological examination showed aripiprazole and sertraline were present in his blood in non-toxic levels.

Independent expert review

53. The court received independent expert review from Dr Olav Nielssen, Forensic Psychiatrist, of Mr Ellis' care and treatment up until the time of his death. One of Doctor Nielssen's roles as a psychiatrist is performing a weekly psychiatric clinic at the Matthew Talbot Hostel. Dr Nielssen gave evidence that he saw Mr Ellis there on two occasions on the 27th of March 2013 and on the 11th of April 2016.

54. Having reviewed all of Mr Ellis' Justice Health records and his own observations, Dr Nielssen concluded that Mr Ellis had a chronic and partly treatment resistant schizophrenic illness on a background of learning problems during his upbringing. He also noted a substance use disorder, particularly of alcohol. He explained that the learning and behavioural problems reported by Mr Ellis during his upbringing may have been an early manifestation of an underlying neurological disorder.

55. Dr Nielssen's explained that Mr Ellis' disorganised thinking and impaired impulse control associated with his severe mental illness deprived him of the ability to live independently in the community without intensive support.

56. It is very sobering to hear these descriptions of the complex difficulties that Mr Ellis was facing during his life. It must have been heartbreaking for his mother and sister to watch their dear family member suffer as he tried to navigate his life.

57. Doctor Nielssen was not critical of Dr Wade's review of Mr Ellis at the MRRC. He noted it was within four days of Mr Ellis' transfer after his attempted hanging in the Sydney Police Centre, Surry Hills. He thought that her plan for a two-week period of changing Mr Ellis' medication was appropriate.

58. Doctor Nielssen was of the view that there was an increased need for psychiatric review of Mr Ellis after the 20th of March to evaluate whether the events of that day were due to symptoms and whether the new medication was working.

59. He formed the opinion that it was not unreasonable for the members of the RIT on the 24th of March to accept Mr Ellis' assurance that he no longer intended to self-harm and to take him out of the observation cell and place him in his cell on his own. He did not regard the delay in Mr Ellis receiving his March depot injection as significant.

60. Doctor Nielssen's opinion is that the lack of review by the mental health nurse and psychiatrists in the period after being placed back in a safe cell represents an inadequate standard of care and that there was no review of the possibly distressing side effects of the change in his medication. Doctor Nielssen stated that the reports of Mr Ellis' disturbed behaviour are at odds with the mental state that was observed by Dr Wade. He said this indicated the need for a specialist review and in particular review of the change in the treatment and that that should have occurred within a few working days. Dr Nielssen is of the opinion that an appropriate standard of care would have involved at least a review by a mental health nurse in the days after his transfer from a safe cell to the single cell. Dr Nielssen gave evidence that it would have been appropriate for a nurse to check on Mr Ellis each day to see how he was going, if the first review by a mental health nurse found him to be particularly changeable, labile or distressed. He also stated that Mr Ellis' two medication refusals on 31 March and 1 April were also indications for further review.

ISSUES

"A Care Pathways Model for Custodial Mental Health; Renewed Model of Care an Implementation Plan"

61. Doctor Sarah-Jane Spencer, forensic psychiatrist who is the Co-director (clinical) Services and Programs and Clinical Director, Custodial Mental Health at Justice Health Forensic Mental Health Network gave evidence that resources constraints led to Mr Ellis not being seen by a psychiatrist for a follow up appointment as was recommended by Dr Wade on the 20th of February 2017. She said that at that time there were two days of staff specialist time per week to cover 138 patients in the Hamden Unit and priority for Mr Ellis' psychiatric review was determined by a case review discussion after the mental health nurse's review on 1 March.

62. Doctor Sarah Jane Spencer provided evidence that a "A Care Pathways Model for Custodial Mental Health; Renewed Model of Care an Implementation Plan" (Care Pathways Model) has been developed. It proposes staffing for 150 new mental health beds at MRRC for patients with major mental illness. It aims to give more holistic care, better treatment, better quality of life and engagement with family, and a more proactive and integrated approach to release planning.

63. Dr Niellsen is very positive about the new Care Pathways Model. He's of the opinion that it is a strong response to the obvious deficits in the Justice Health mental health care.

64. Dr Spencer is of the opinion that the implementation of this model will result in less demands being placed on the staff in Darcy so that they will be able to be more responsive to patient needs.

65. Funding for this new model is still in question.

66. I note that in the inquest into the death of MH dated 14 July 2021 that the State Coroner noted that the Ministry of Health is considering the Care Pathways Model and she provided a copy of her findings in that matter to the Ministry of Health for consideration together with their consideration of the new model.

67. I also note that in the Inquest into the death of F dated 11 June 2021 that Deputy State Coroner Ryan recommended that Justice Health and Forensic Mental Health Network use her findings to advance the position before the Ministry of Health for the implementation of the Care Pathways Model.

68. It is only humane that the seriously mentally ill who are being held in the custody of the State are treated with appropriate and adequate care. This certainly didn't happen in Mr Ellis' case. I strongly support the adaption of the new model. I will arrange for a copy of these findings to be forwarded to the Ministry of Health to include in their considerations on the Care Pathways Model.

Waitlist for psychiatric review

69. Doctor Spencer said that the failure to transfer Mr Ellis to a waitlist for review by a psychiatrist from the Hamden wait list to the Darcy wait list once he was moved to Darcy was a critical process breakdown. She explained that there was no routine review within the Darcy Unit of people who had come off an RIT. Doctor Spencer agreed that this is a very unsatisfactory situation and that where a RIT team refers a person to a psychiatrist that is certainly something that should trigger a wait listing that would enable the person in question to be seen.

70. I have been informed by Justice Health that since Mr Ellis' death the network has created a single waiting list which covers all patients in the MRRC who are waiting to see psychiatrists. In those circumstances, patients being transferred between units, including Hamden and Darcy, are no longer moved between waiting lists. This ensures that patients are not inadvertently lost to follow up when moving between areas within the MRRC and also ensures that patients are not placed at the end of a new waiting list because they have moved between units.

Management in safe cells

71. Doctor Spencer agreed with Doctor Neilson that the lack of review by a mental health nurse and a psychiatrist of Mr Ellis while he was in the safe cell represented less then adequate standard of care. The only support offered by Justice Health while Mr Ellis was in the safe cell was when he was given his medications. This situation persisted after he was released from the safe cell and placed in the Darcy Unit.

72. Doctor Nielssen explained that being in a safe cell would be distressing to anyone, but if you are experiencing distressing auditory hallucinations, it would be doubly distressing. He formed an opinion that it was more probable that Mr Ellis' mental health continued to deteriorate during the four days he was locked in the camera cell. The RIT mental health nurse said that Mr Ellis told them that being in a safe cell was making him unwell.

73. One of the inmates who gave evidence in this inquest said that he had been in a safe cell. He stated that he would stay in there for 23 to 24 hours a day only being released for a shower.

74. The Commissioner for Corrective Services informed the court that now when a RIT assessment has been conducted and it is considered safe for them to do so, inmates on a RIT spend part of the day outside a safe cell.

75. The Commissioner acknowledged that there still needs to be a system developed for those inmates assessed as being at high risk of self-harm to be better supported in their safe cell.

76. Dr Nielsen explained that good mental health care in custody can reduce the number of suicides. He said that reassuring people and ensuring their safety would assist as people often commit suicide out of the perception of danger. He said that in addition to treatment for their mental illness that other services such as psychologists, occupational therapists or social workers can play a positive impact on the likelihood that someone might commit suicide.

77. I intend to recommend that the Commissioner for Corrective Services and Justice Health consider what steps in practice could be made to deliver better support and care to inmates who are placed in safe cells, and have recently been released from safe cells, including the provision of multidisciplinary services such as occupational therapist, social workers and psychologists, in order to minimise the likelihood of deterioration of their mental health.

Risk Intervention Team

78. Mr Ellis was not seen by a RIT for 48 hours after his risk of self-harm was identified on 20 March 2017. The mental health nurse who formed part of the RIT on 22 March gave evidence that at that time the RIT reviews were conducted every 48 hours in the Darcy Unit. This was contrary to the prevailing Corrective Services NSW policy that required a RIT review every 24 hours.

79. One of the other mental health workers gave evidence that it was not feasible to do reviews within 24 hours because of the number of reviews required. He indicated that reviews were happening every two days and sometimes three days due to the workload.

This is borne out by Mr Ellis' timeline in custody. He was first seen by a RIT on 17 February 2017 when an order was made for him to remain in a safe cell. He was given a review date of 19 February 2017. That review in fact did not occur until three days later, on 20 February 2017.

80. The Acting General Manager, State-wide Operations, Custodial Corrections Branch, Corrective Services NSW gave evidence that RIT reviews are now being conducted at 24 intervals in the MRRC. In those circumstances I do not propose to make any recommendation in relation to the fact that in 2017 the prevailing policies were not being adhered to.

81. A Health Problem Notification Form (HPNF) was completed by the mental health nurse who formed part of the 22 March 2017 RIT. It simply stated that Mr Ellis' symptoms were "active RIT due to threat of self-harm" The second HPNF completed stated "RIT terminated. 1 out cell placement. Transfer to Hamden when bed becomes available." These forms provide the MRRC officers with information on Mr Ellis 'mental health. Doctor Nielssen gave evidence that there were several signs and symptoms that could have been included upon the forms to assist the Corrective Services officers in managing Mr Ellis' mental health issues.

82. This inquest highlighted that the multidisciplinary RIT could have functioned better if the HPNF form had provided more detail of Mr Ellis' symptoms. It is an opportunity for the corrective services officers to be better placed in their management of inmates. I propose to recommend that there be further training of Justice Health mental health staff in the significance and importance of thoroughly completing the HPNF forms.

Knock up Calls

83. During the evening between 1 and 2 April 2017, neighbouring inmates reported hearing Mr Ellis saying things like *"I love you mum"*, *"don't listen to Dad"*, and *"I wanna kill myself"*.[19] After this, inmates heard a fumble in Mr Ellis' cell with no further sounds from that point onwards. One of the neighbouring inmates, Mr Clayton, said in his statement that Mr Ellis himself buzzed up (or 'knocked up' – ie made a call from his cell) and asked for medication (after around 8pm) and that officers attended the cell at least once, without any nurses. Mr Clayton's signed statement, dated 18 May 2020, refers to officers saying that they would come back with medication but also says that *"They pretty much laughed it off"*. Mr Claytons cell mate did not recall hearing officers attend the cell, but he did think that Mr Ellis had asked for medication.

84. Cell call records do not indicate that Mr Ellis made any calls or knock ups from his cell at any time after 5:30 PM on the 1st of April 2017.

85. The call cell records indicate that two knock ups were made between 2:00 and 3:00 AM on 2 April 2017. Mr Clayton's oral evidence was that he was unable to say clearly whether Mr Ellis knocked up before, or after the pill round on the 1st of April 2017. It is likely that his recollection of the timing of the knock up is inaccurate.

86. The cell call records indicate that there were two calls of 19 seconds and 3 seconds duration answered by the central control at the MRRC rather than in the Darcy office. The last one was at 2:43 AM. Unfortunately, there are no recordings of the content of the knock-up calls.

---

[19] *Ibid* at [9], p. 3.

87. The officers on duty at central control of the MRRC at the relevant time provided statements that they did not recall this shift.

88. It is most unfortunate that recordings of those knock up calls are not available for this inquest. In all deaths in custody of a matter of this nature it is imperative that a log of the knock up calls, and recordings of the contents of the calls together with all relevant CCTV footage be retained and available for the Officer in Charge of the coronial investigation.

89. The Functional Manager Security, MRRC informed this court that as at 1 and 2 April 2017 knock up calls were not audio recorded at the MRRC. That situation has subsequently changed. Since 14 June 2018 all knock up calls in MRRC are recorded. The current policy requires the audio of the knock-up calls to be retained for a minimum of two years and accordingly are now available to any coronial investigation'

Cell checks at night

90. Doctor Nielssen informed this court that in his experience people in custody normally take their lives at night because this is a time when there is less supervision and the most opportunity. A senior correctional officer who gave evidence in this inquest said that additional random physical checks of inmates at night were not being conducted in 2017 in the Darcy Unit.

91. The Commissioner of Corrective Services made a submission that there is a policy requiring officers on the B watch to conduct regular patrols and security checks streetwise in accommodation areas. The Commissioner is open to considering adding in a reference to that policy that there be additional random patrols of the Darcy Unit. Given the type of inmates held in Darcy I agree that additional random officer patrols at night within Darcy may help prevent another person take their life.

Ligature Points

92. Assistant Commissioner Tyler gave evidence of a programme that was in train as at October 2021 to allocate some $6 million to the modification of cells for the purpose, among other things, of removing ligature points.

93. In September 2020 a new facility at the MRRC was constructed. The new facility contains 328 new cells and houses up to 440 inmates. All of the new cells incorporate anti ligature design principles.In 2021/22 $6 million of capital funds has been allocated to refurbishing cells to remove obvious hanging points in NSW correctional centres. This funding has allowed 38 cells in Hamden to be refurbished. I am informed there are operational difficulties closing large areas of the MRRC for refurbishment works to be undertaken and that it is necessary to close small numbers of beds at a time for it to occur.

94. At this point, all cells in Darcy 3 have been refurbished. Cells in Darcy 1, 2 and 4 are prioritised for refurbishment. It is proposed to refurbish 18 cells in Darcy 1 and 38 cells in Darcy 2 in the financial year 2022/23.

95. I commend this program and recommend that all Darcy Unit cells remain a priority for the removal of ligature points.

Conclusion

96. After being assessed by Dr Wade on 20 February 2017, Mr Ellis was never reviewed by a psychiatrist in the six weeks that he spent in custody until his death. During that time, he exhibited signs of psychosis and expressed concerns about his new medication not working.

97. He was taken to a safe cell which is a 24-hour camera cell where he was stripped to his underpants. He remained in that cell for four days without any psychiatric or any other therapeutic support.

98. He was then transferred to a single cell in the Darcy Unit where no further mental health follow up occurred prior to his death. Darcy Unit houses new intakes often coming down from drugs and alcohol. This court heard evidence that it is noisy and chaotic.

99. Dr Wade, in her initial assessment, had referred Mr Ellis to the Hamden Unit. This is a mental health dedicated unit which has two psychiatrists and a full time Mental health nurse. Mr Ellis' mental health was complex, and he had a long-term high-level risk of harm to himself. It would have been far more appropriate for him to at least been housed there. The care and treatment that Mr Ellis received prior to his death was inadequate and I propose to make the recommendations as set out below.

100. I express my condolences to Mr Ellis's family and confirm my opinion that the Care Pathways Model should be implemented as soon as feasible. I will arrange for a copy of these findings to be forwarded to the Ministry of Health to include in their considerations on the Model.

Findings: s 81 Coroners Act 2009

I find that Mr Gavin Ellis died on 2 April 2017 at the Metropolitan Remand and Reception Centre, Silverwater Correctional Centre, Holker Street, Silverwater as a result of hanging. He died as a result of actions taken by him with the intention of ending his life.

Recommendations:

To the Commissioner of Corrective Services New South Wales:

1. I recommend allocating funding as a priority, to the removal of ligature points in all Darcy Unit cells at the MRRC; and
2. I recommend consideration be given to adding a requirement for additional random patrols of the Darcy cells in the roles and responsibilities of officers on the B watch at MRRC.

To the Commissioner of Corrective Services NSW and the Chief Executive Officer, Justice Health and Forensic Mental Health Network:

1. I recommend that consideration be given to what steps could be made to deliver better support and care to inmates who are placed in safe cells, and to inmates who have recently been released from safe cells, including the provision of multidisciplinary services such as occupational therapists, social workers, and psychologists, in order to minimise the likelihood of deterioration of their mental health.

To the Chief Executive Officer, Justice Health and Forensic Mental Health Network:

1. I recommend that further training and education be given to Justice Health staff in completing the Health Problem Notification Form in relation to inmates who have been subject to a RIT, for the purpose of assisting Corrective Services NSW offices identify relevant signs that may indicate risk of self-harm.

Magistrate C Forbes
Deputy State Coroner
18 August 2022
Coroners Court of New South Wales