CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of IM
Hearing dates:	9 February 2022
Date of findings:	9 February 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Brett Shields, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2019/00267007
Representation:	Ms. B Notley, Coronial Advocate Assisting the Coroner
Findings:	Identity: IM Date of death: 3 September 2019 Place of death: Cessnock Correction Centre, Cessnock, New South Wales Cause of death: Sharp force injuries of the neck and left arm Manner of death: Suicide
Recommendations	Nil
Non-publication orders:	See Annexure A

1. Introduction

1.1. At the time of his death, IM was 37 years old and in lawful custody at the Cessnock Correction Centre ('CCC'), Cessnock, New South Wales, on remand.

1.2. On 21 July 2019 IM was charged with a number of sexual offences against a child. IM was taken before Newcastle Local Court on 22 July 2019 and refused bail, and thereafter held on remand at CCC.

1.3. On 3 September 2019 IM was found by his cell mate, in the shower of the cell, with self-inflicted wounds to the neck and left arm at the wrist. Emergency services attended however IM could not be revived and he was pronounced deceased at the scene.

2. Reason for the inquest

2.1. The *Coroners Act* 2009 ('the Act') requires a Coroner to investigate a 'reportable death', as that term is defined in the Act, to enable a Coroner to the make the findings required by sec. 81 of the Act. The findings concern the identity of the person who died, when and where they died, and the cause and the manner of their death. In this context the manner means the circumstances in which they died.

2.2. A person charged with a criminal offence, or who is sentenced to a term of imprisonment upon conviction, can be detained in lawful custody and, in so doing, the State assumes responsibility for the care of that person. Sec. 23 of the Act makes an inquest mandatory in cases where a person dies while in the custody of the State. The open administration of justice requires, and the community appropriately expects, that the death of a person in the custody of the State will be properly and independently investigated to ensure that the State met its responsibility for the care of that person.

2.3. The coronial investigation into the death of IM did not identify any evidence to suggest that he was not appropriately cared for and treated while in custody.

3. IM's life and background

3.1. IM was born on 19 June 1982 and was aged 37 at the time of death. The brief otherwise contains very little information about his life, apparently as a result of the reluctance of his family to speak to Police arising from the circumstances in which he was charged.

4. IM's custodial history

4.1. After arrest IM was charged and then taken before Newcastle Local Court on 22 July 2019, where he was refused bail, and he was thereafter held on remand at CCC.

4.2. At the date of his death IM had been in custody on remand for 44 days.

5. IM's medical history

5.1. IM underwent a Reception Screening Assessment when he first entered custody on 22 July 2019 which included a mental health assessment. The screening tool showed a mild level of distress with a diagnosis of mild depression and/or anxiety. IM was assessed as not at risk to himself or others. IM reported significant use of alcohol however he was assessed as not in alcohol withdrawal.

5.2. After initial assessment the evidence shows that IM had the following further contacts with Justice Health:

5.2.1. On 1 August 2019 IM completed a patient self-referral from requesting medication to treat his depression. IM completed a consent form for release of information that was sent to his general practitioner. When received that information included a discharge summary from Maitland Private Hospital that recorded previous admissions to the mental health unit at Maitland Hospital including in March 2017 when he was admitted for stability of mood in the context of multiple stressors and substance misuse and when he was prescribed medication;

5.2.2. On 12 August 2019 IM was prescribed medication for his anxiety and he collected that medication daily from the Health Centre at CCC;

5.2.3. On 18 August 2019 IM called the Justice Health and Forensic Mental Health Network Mental Health Helpline ('the Helpline') and said that he was depressed and wanted to speak with someone about his recent divorce and an Apprehended Domestic Violence Order made against him for the protection of his former wife and child. During the call IM guaranteed his own safety and denied and thoughts of self-harm;

5.2.4. On 20 August 2019 again called the Helpline and he was referred to the telehealth psychiatrist. IM was awaiting that consultation at the time of his death;

5.2.5. On 3 September 2019 IM again called the Helpline and he said that he felt remorseful and had limited support from outside custody. During the call IM again guaranteed his own safety and denied any thoughts of self-harm; and

5.2.6. Later on 3 September in the circumstances described below.

5.3. After IM's death enquiries of IM's former spouse revealed that after his admission to Maitland Hospital in March 2017, IM was under the care of a private psychotherapist and was medicated. IM's spouse also revealed that IM was at times not compliant with his medication, with resulting adverse changes in his behaviour including reckless and risk taking behaviour and expressions of suicidal ideation. That information was not disclosed by IM to Justice Health during the Reception Screening Assessment on entry into custody or otherwise revealed in the medical records obtained from his general practitioner, and was therefore not known to Justice Health.

6. 3 September 2019

6.1. On 3 September 2019, IM made 4 telephone calls:

6.1.1. At 9.32 he called his father, Mr. SM and they spoke for 6 minutes. SM has spoken to Police and he stated that the conversation was normal, he offered his support to IM and told him that his brother intended to visit, and that IM gave no indication of any intention to self-harm;

6.1.2. At 13.31 he called the Helpline for approximately 9 minutes. The conversation is set out above and during the call IM again guaranteed his own safety and denied any thoughts of self-harm;

6.1.3. At 14.41 he called his legal representatives and spoke with Mr. W for approximately 7 minutes. Mr. W has spoken to Police and he stated that during the call IM was seeking information about the length of any custodial sentence that might be imposed upon him; and

6.1.4. At 14.53 he made an unsuccessful attempt to contact his father.

6.2. IM was housed in cell G32 which he shared with one other inmate. At approximately, 15.00 IM and the other inmate were locked in their cell and at approximately 15.20 IM walked into the shower area of the cell, which was screened for privacy using sheets and a towel. The other inmate heard the shower start, and IM make a comment about the shower, and then heard a groan, which he ignored as he thought that IM may be crying in the shower, which had previously occurred. The shower operates on a 6 minute timer and the other inmate heard the shower stop. When IM did not emerge from the shower the other inmate looked behind the screening and saw IM seated on the floor of the shower with a large amount of blood running onto IM's chest and stomach from a wound on the neck.

6.3. The other inmate activated the 'Knock Up' button in the cell and spoke by intercom to Corrective Services New South Wales Staff ('CSNSW') informing them of the situation, and he was instructed to use a towel to apply pressure on the neck wound and move IM into the recovery position on his left side. CSNSW staff including Nurses entered the cell at 16.04 and CPR was commenced while awaiting the arrival of Ambulance personnel and

the Westpac Rescue Helicopter with medical practitioners on-board. The Ambulance and paramedics arrived at 16.16 and they continued the CPR until 16.40 when the Westpac Rescue Helicopter and medical practitioners arrived. IM was pronounced deceased by a medical practitioner from the Westpac Rescue Helicopter at 16.47. The events in the cell after the entry of CSNSW staff were recorded on a hand held video.

6.4. A broken section of a razor was found in the shower, and 5 hand-written letters expressing suicidal ideation, arising from the circumstances in which he was charged and the likely consequence, were located in a box under IM's bed in the cell.

7. The cause IM's death

7.1. IM was taken to the Department of Forensic Medicine in Newcastle where an external post-mortem examination was performed by Dr. Hannah Elstub, forensic pathologist, on 6 September 2019.

7.2. In the autopsy report dated 2 June 2020 Dr. Elstub opined that the cause of death is the consequences of sharp force injuries of the neck, including the right jugular vein, and the left arm at the wrist.

8. Conclusions

8.1. The evidence establishes on the balance of probabilities that the cause of IM's death was the self-inflicted sharp force injuries of the neck and left arm.

8.2. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health to alter the outcome or that any aspect of the medical care provided to IM while in custody contributed in any way to his death.

9. Findings

9.1. The findings I make under sec. 81(1) of the Act are:

Identity	IM
Date of death	3 September 2019
Place of death	Cessnock Correction Centre, Cessnock, New South Wales
Cause of death	Sharp force injuries of the neck and left arm
Manner of death	Suicide

10. Closing

10.1. I acknowledge and express my gratitude to Ms. B Notley, Coronial Advocate, for her assistance both before and during the inquest. I also thank Detective Senior Constable Ash Cooper for conducting the Police investigations and for compiling the initial brief of evidence.

10.2. On behalf of the Coroners Court of New South Wales, I offer condolences to IM's family.

10.3. I close this inquest.

Magistrate Brett Shields
Deputy State Coroner
Coroners Court of New South Wales