CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr ZH
Hearing dates:	12 October 2022
Date of findings:	12 October 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:	2021/230432
Representation:	Coronial Advocate Assisting the Coroner, Mr Kai Jiang
	Herman Yeh, Solicitor, Axegal, for Senior Next of Kin
	Ms Claire Dunn, Solicitor, DCJ Legal for the NSW Commissioner of Corrective Services
	Mr Tim Hackett instructed by Mr Stanley Martins, Ingenium Legal for MTC Broadspectrum
	Mr Hugh Norris for Justice Health & Forensic Mental Health Network
	Ms Seun Idowu & Ms Rebecca Dodd, Hall & Wilcox for St Vincent's Correctional Health

Findings:

I make the following findings in relation to the death of Mr ZH, pursuant to s81 of the Coroners Act 2009 NSW:

Identity:	ZH
Date:	Between 11pm on 10 August 2021 and 7:41am on 11 August 2021
Place:	Cell 8 of Unit 4E Lower Ground at the Parklea Correctional Centre
Cause:	Hanging
Manner:	Self-inflicted

Recommendations Nil

Non-publication orders: A Non-publication order was made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) on application by Corrective Services NSW and MTC Broadspectrum – Refer Annexure A

A Non-publication order was made pursuant to section 75(2)(b) of the Coroners Act 2009 (NSW) in relation to the name of ZH and any of his family members.

JUDGMENT

Introduction

1 An Inquest was held into the death of Mr ZH, who died in Cell 8 of Unit 4E at the Parklea Correctional Centre between approximately 11pm on 10 August 2021 and around 7:41am on 11 August 2021.

2 Because Mr ZH died while in custody, an inquest is required by the Coroners Act 2009 NSW (the Act).

3 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.

4 I would like to commence these Reasons for Decision by expressing my sincere condolences to the family members of Mr ZH for their loss. Mr ZH's family members include his mother, LH who resides in China, and his grandmother, Ms VK, and his cousin, both of whom reside in Australia.

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.

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 ZH'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, other inmates, and family members, and their 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, Detective Senior Constable Allan.

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.

11 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered to the inquest. All of that material, and the evidence at the inquest, has been considered in making the findings detailed below.

Background

12 Mr ZH was born on 23 May 1992, in China. He was 29 years of age at the time of his death. His was also known by his English name and his friends called him a third name. It appears that Mr ZH was of Christian faith.

13 In 2004, Mr ZH immigrated to Australia with his father, Mr XZ. His mother, the Senior Next of Kin, Ms LH, remained in China. His parents were separated around 2002. His relationship with his mother was estranged due to limited contact after he came to Australia. It appeared that Mr ZH only re-established contact with his mother in June 2020.

14 Upon arrival in Australia, Mr ZH and his father lived in Cabramatta with his grandmother, Ms VK, who was of Russian background. Mr ZH has no siblings. His childhood was lonely. He was raised and cared for by his grandparents. He appears to have remained close to his grandmother over the years. Mr ZH attended Cabramatta High School. However, he left school in year 8. He then attended the Ultimo TAFE and worked as a gyprocker.

15 Around 2011, Mr ZH's father passed away due to Oesophageal Cancer. His grandfather passed away in 2013. He has one cousin in Sydney who is the son of his paternal aunt, Ms LA. He shared a close relationship with his aunt. Unfortunately, she passed away in 2015. Mr ZH has struggled ever since with the grief over the multiple successive deaths of those dearest to him.

16 As far as is known to his family and friends, Mr ZH was never married and did not have any children. He had a girlfriend, but the relationship broke down; reportedly this happened in early 2016.

Criminal History

17 As Mr ZH died in custody, it is relevant to report the reason that he was in custody.

18 On 4 August 2014, Mr ZH was charged with offences including the supply of prohibited drugs. He received a sentence of imprisonment of 14 months, commencing on 4 August 2014 until 3 October 2015, and he was released to parole on 3 April 2015. On 14 May 2015, however, whilst still on parole, he was again arrested and charged for being involved in the supply of Methylamphetamine - the charges included the supply of prohibited drugs (over large commercial quantity). On 23 June 2017, he was sentenced to 9 years imprisonment (from 3 October 2015 until 2 October 2024, with a non-parole period of 6 years and 9 months commencing from 3 October 2015). The earliest release date, to parole, was 2 July 2022. Mr ZH lodged an appeal against the severity of the sentence but this was dismissed on 4 May 2018.

Correctional facilities/history

19 Mr ZH has moved around multiple correctional centres across NSW. His English was limited but he was able to communicate effectively without an interpreter. His English reportedly improved during his time in custody. Mr ZH was described to be quiet, polite and compliant, with a good work ethic. In general, he appeared to have interacted well with other inmates and was liked by Correctional Officers. However, there were occasions where Mr ZH was disciplined for misbehaviours and offences ranging from intimidation of Correctional Officers to possession of prohibited drugs and tobacco. There were two occasions where Mr ZH requested to be transferred to another correctional facility due to fears for his safety. However, in March 2019, Mr ZH also stated that he lied about being stood over by another inmate in an application for Special Management Area Placement, so he could be transferred to a correctional facility of his choice.

20 On 13 March 2021, Mr ZH was transferred to Parklea Correctional Centre. Since 13 May 2021, he was housed in Cell 8 of Unit 4E which is a minimum-security area. He got along well with the inmates in the same area. He was described to be respectful and with a cheerful demeanour.

21 Mr ZH worked in various jobs whilst in custody. He enjoyed working in the kitchen and was up skilled in hospitality. He was last employed as a cleaner at Parklea. But this employment was terminated on 5 August 2021 due to his recent continued non-attendance. He is recorded as failing to report for work on the second, fourth, and fifth of August 2021.

22 At the time of his death, Mr ZH was in lawful custody at Parklea Correctional facility.

Description of Mr ZH ’s gaol accommodation at the time of his death

23 The officer-in-charge in charge of the Police and coronial investigation, Detective Senior Constable Allan, describes the accommodation in which Mr ZH resided as follows. Area 4E lower left, is bordered by a chain-link gate and

fence at the front of the unit. The unit is two storeys and the upper storey is separated from the lower level by stairs and landing outside the unit. There was one single entry door into the 4E lower left unit with a CCTV camera above the outside of the door. Walking through the entry door, there is a living room area with a television on the left-hand wall with a cabinet underneath the television. There were a number of lounges and lounge chairs. The lounge area was Open Plan with a kitchen area opening up from the lounge area. There were two long tables with chairs, a cupboard, refrigerator and sink and meal preparation area. Off the communal living area is a hallway with inmate cells down each side. On the left-hand side of the hallway are six cells and on the right-hand side there were four. At the far end of the hallway on the right-hand side is a communal bathroom. Area 4E is a minimum-security area, and is used to house inmates that are classified as C2 and C3. C2 inmates are low risk and C3 are low risk and often have weekend leave outside the correctional facility.

24 Investigating Police, including Detective Senior Constable Allan, examined the cell in which Mr ZH was housed. This was cell number eight in building 4E. There was a cupboard to the right-hand side of the cell near the door. The cupboard had one half as shelving (right side) and the left side had a door, hang rail for clothing and a shelf on top. On the hang rail was what appeared to be a pair of green tracksuit pants, another piece of green fabric which was possibly a bedsheet, and a white piece of fabric which appeared to be cut from bedding, possibly a cotton type blanket. This was the clothing hang rail that Mr ZH had been located hanging from. Next to the cupboard was a white desk that had a number of items on it. Police saw a razor, as well as a razor blade which had been removed from the razor - this was next to a piece of white fabric similar to what was hanging in the cupboard. The inference arises from this observation that the razor blade had been used to cut strips from the white blanket, these strips were then used as the ligature (to hang himself). The white cotton strips that were used a ligature were delivered to the forensic pathologist who examined the ligature, as part of the autopsy examination. As noted below the pathologist found Mr ZH’s injuries from the hanging were consistent with the ligature used in the hanging.

25 At the end of the desk in the cell, was a single bed which had a fitted green bedsheet, a coloured doona cover, a white coloured blanket and a pillow in a green pillowcase. Next to the bed was a small bedside table which appeared to have been made from a cardboard box. On top of the table was green fabric fashioned like a tablecloth, magazines, books, a drink bottle, a roll of toilet paper and some other items, including what appeared to be razorblades. Next to the bedside table was a small white garbage bin. On the wall opposite the cupboard area was a wall calendar and a string bag which was hanging from a hook. There was no intercom or Stenophone located in the cell.

26 Investigating Police took photographs of the cell and its contents which are contained in the brief of evidence. At the time investigating Police arrived Mr ZH was in his cell and he was examined by the Police. Police immediately interviewed a number of Correctional Officers and also inmates. Statements were obtained from various inmates.

27 There was a Stenophone communication device in the common area of the wing but this had not been used by Mr ZH, or other inmates, in the hours before his death. There is one CCTV camera within the wing however it is above the outside of the entry/exit door to the wing. Police were advised that inmates were locked into the lower level of each wing at the evening muster and are free to move around within the wing as they please.

28 Police observed that prior to Mr ZH being removed from his cell, a chaplain attended and performed a blessing, Mr ZH was then taken to the Department of Forensic Medicine for autopsy examination.

29 Police seized a number of items from the cell for further examination, these included the razorblades, the calendar, the diary which was found in the cupboard, a notebook which was found in a cupboard, a small satchel containing some tablets, and two letters written in Chinese characters which appeared to the Police to be from other inmates written to the deceased (these were found in the cupboard). The Police carefully searched the cell for any other relevant contents. Full crime scene examinations were undertaken

of the cell and the building in which the cell was located. These investigations are detailed in the brief of evidence

Immigration issues

30 Mr ZH's criminal offending had resulted in the cancellation of his Australian permanent residency. The immigration status service of Australian Border Force advised the officer-in-charge of the Police and coronial investigation that the deceased had been a permanent resident of Australia, however his permanent resident Visa was cancelled in 2015. As he was serving a custodial sentence, he was placed on a Bridging Visa so that he could be lawfully in Australia, however given cancellation of his permanent resident Visa, upon release from custody he would not be lawfully in Australia. He would be subject to immigration detention and deportation upon his release from custody. Mr ZH however appeared hopeful of remaining in Australia upon release. On 27 July 2021, his immigration status changed to being a lawful non-citizen by virtue of a Bridging Visa, as long as he remained in custody.

31 When investigating Police reviewed the Correctional services warrant file they noted that a letter from the Department of Immigration and Border Protection dated 27 July 2021 is contained in the file, and this records the grant of the Bridging Visa E whilst on remand or in custody. The letter also advises that once the Bridging Visa ceases (after his term of custody) Mr ZH will become unlawful and must be detained, with deportation from Australia possible. The warrant file also recorded that on 5 August 2021 Mr ZH made a request applying for a C3 classification and stated he had just got a Bridging Visa and therefore would be able to work in the community.

32 Investigating Police noted an inmate case note report that on 27 July 2021, it is documented that Mr ZH was handed a notification of grant of Bridging Visa E. On 27 July 2021 he started to fail to attend at his work within the gaol. He was cautioned and told to rectify it otherwise it would lead to dismissal from employment. On 30 July 2021 a staff member assisted Mr Zang to liaise with

the Chinese Embassy. He was told to come to the office at 2 PM, staff used the loudspeaker to call for Mr ZH at that time however he did not attend. A further three attempts were made to alert him, via the loudspeaker, however he did not attend. It appears that Mr ZH may have become more aware of his immigration status difficulties.

Medical History

33 There is no medical history available prior to Mr ZH's incarceration. He worked out in the gym and kept himself physically fit whilst in custody.

34 Mr ZH was a smoker and started drinking alcohol at the age of 15. In 2011, he started using methamphetamine following his father's and grandfather's death. At the same time, he started smoking cannabis and taking ecstasy daily. Records indicate that his drug use continued whilst in custody, using both methamphetamine and buprenorphine. In January 2020, Mr ZH was referred to participate in the Intensive Drug and Alcohol Treatment Program but in August 2020, he declined to participate.

35 Mr ZH was lactose intolerant and had gastrointestinal issues since his teenage years. He was placed on a lactose free diet whilst in custody. However, he continued to consume dairy products through buy-ups (purchase of items in gaol). Despite being repeatedly educated about the importance of keeping a lactose free diet, Mr ZH continued to request to be placed back on a normal diet.

36 Since 2015, Mr ZH would often seek medical assistance for bowel related issues. In September 2020, he was admitted to the Muswellbrook District Hospital, a CT scan was done and he was diagnosed with colitis. Two referrals for colonoscopy were made for Mr ZH, one in September and another in November 2020, but he had cancelled both of them. In a form dated 25/09/20 he stated he did not want to attend the colonoscopy because "I feel better. I don't need the colonoscopy". In the form it stated he had been advised the condition may deteriorate.

37 Mr ZH suffered from chronic nasal congestions and exhibited symptoms of hay fever with episodes of runny nose, sneezing and headaches. On 22 February 2019, a CT scan found that there was a nasal septal deviation to the left, pneumatisation of right middle turbinate, minor deformity of nasal bones, and mild paranasal sinus inflammatory changes. Mr ZH never properly disclosed the cause of the injuries to his nose.

38 Mr ZH does not have any formal diagnosis of mental health conditions but claimed to have depression due to grief over the death of his aunty, and anxiety over the uncertainty of his future after release. He made some self-referrals regarding stress, coping, and sleeping issues. On 8 September 2016, he was seen by a psychologist. He stated that he had attempted self-harm previously in 2014 by cutting himself to the arm because of his relationship breakdown. At the conclusion of the session, no immediate concerns were identified. A referral was made for him to be assessed by a Chinese speaking psychologist. However, he did not attend the appointment.

39 There was a self-harm alert created on 27 December 2017. However, the related incident report was in relation to Mr ZH suffering a swelling left eye and scratches to his neck due to a suspected physical altercation with another inmate. On 12 March 2018, during another psychology consultation, Mr ZH reported good sleep, appetite, and exercise. He denied any suicidal ideations or thoughts of harming himself or others. He reported that he was not experiencing any perceptual disturbances. Similarly, on 6 February 2019 no mental health issues were identified during a follow up consultation.

40 The inmate transfer notes, and new inmate reception screening questionnaires, indicated that Mr ZH denied any intention to self-harm or commit suicide. On 19 January 2021, the last Health Problem Notification Form before his transfer to Parklea Correctional Centre recorded that he denied any acute medical and mental health issues at the time. However, a review of classification assessment carried out on 14 May 2021 noted that Mr ZH has a history of depression.

41 In August 2021, the week before his death, Mr ZH was observed by another inmate in the bathroom with blood running down his left forearm. However, he stated that he simply slipped and fell. No reports were made to Corrective Services in relation to this.

42 None of Mr ZH's family or friends were aware of any mental health concerns or previous self-harm attempts.

Events leading up to death

43 It appears that on 23 July 2021, Mr ZH learned that his ex-girlfriend is now with someone else. It is unclear how he was provided this information or if it was true. At 8:54pm on the same day, he called his mother. He had not contacted her in a long time. He stated that he had not been in a good mood lately. He was upset about the information regarding his ex-girlfriend and was concerned about repercussions from his previous criminal associations. Ms LH told him not to take these things too seriously. She told him that he can always return to China and start a new life.

44 On 27 July 2021, Mr ZH was notified of the grant of a Bridging Visa which changed his immigration status to a lawful non-citizen while he was on remand in custody. However, the Bridging Visa would cease upon his release from custody. On 28 July 2021, Mr ZH called his grandmother and told her that he may be released in August. It is unclear if Mr ZH fully understood the meaning and effect of this Bridging Visa. On 30 July 2021, he sought assistance from the Correctional Officers to contact the Chinese Embassy. This was probably to arrange for a new Chinese passport as he had lost his when he entered custody. A call was put through for him at 12:30pm, but that was outside of their working hours. Mr ZH was told to return to the office at 2pm. However, he did not return despite being called over the loudspeaker.

45 Mr ZH's behaviour appeared to have changed after the grant of the Bridging Visa and learning about his ex-girlfriend. He stopped attending his employment. He was cautioned. However, he continued to miss his employment. On 5 August 2021, his employment was terminated. On the

same day, Mr ZH applied to be reclassified to C3. In the application he stated that he was just granted a Bridging Visa and that he was able to work in the community. The reason for the re-classification application was for work release to save money to help his family.

46 On 6 August 2021, Mr ZH was interviewed by the Parklea Parole Services. His case plan was discussed. He nominated to stay with his grandmother in Cabramatta upon his release on parole. He noted that his focus was to get re-classified to C3 so he can have work release, and that he should now be eligible given the recent grant of his Bridging Visa. He stated that he intended on going back to China at the completion of his parole. During the interview, Mr ZH slurred his speech but denied having taken any substances.

47 Other inmates also noticed that Mr ZH was acting strangely. He would sometimes call out to other inmates that he loved them for no apparent reason. He was noticeably upset about the situation with his ex-girlfriend. Most inmates housed in Unit 4E were aware that his wife or girlfriend cheated on him. Mr ZH even asked at least 2 inmates to punch him in the face. Although some thought that was a ploy to be moved to another correctional facility. One inmate who reported to Police this request by Mr ZH for him to punch him in the face, also reported that Mr ZH had said to him:

> "I have been bad. I need to be dealt with"

48 The week before his death, Mr ZH was found in the shared bathroom at around 2 to 3 am in the morning with blood on his arm, the floor and the bathroom sink. The inmate who saw this suspected that Mr ZH had cut himself. But Mr ZH assured that he was okay, and that he simply fell from a chair. This incident was not reported to the Correctional Officers. Mr Zhang was observed to be wearing long sleeve tops since that date.

49 On 8 August 2021, Mr ZH contacted his best friend Mr BR. At the end of the call, Mr ZH sent kisses over the phone to BR's one year old daughter before saying goodbye to his friend. On the same night, he also called his grandmother. He said that he will only be released on 2 July 2022 but he has

made an application for early release so he can work in the community. Mr ZH told his grandmother to take good care of herself. Those were the last words to his grandmother.

50 Around 6:40pm on 10 August 2021, an evening muster was conducted, and all inmates housed in Unit 4E were accounted for. The external gates into Unit 4E were locked. Mr ZH stayed mainly in the shared kitchen area. He had taken a shower earlier that evening which was not his usual routine. At 10:30pm, Mr ZH had a conversation with another inmate in the lounge room where he talked about his ex-girlfriend cheating on him, not being able to see his 7-year-old son, missing his family and that he was saving money to return to China. They talked for about 15 minutes. Mr ZH was described to have been stressed during the conversation but seemed to have lightened up when they finished talking. Mr ZH went into his cell shortly after. He was last seen alive at around 11pm that day.

51 At 7:14am on 11 August 2021, Mr ZH did not exit his cell when the morning muster was called. His cell door was not locked. An inmate opened his cell door slightly to wake him up before the Correctional Officers came knocking. This was done as he was known to sleep with ear plugs in and would often be late for morning muster. Correctional Officers entered the cell and found Mr ZH kneeling on the floor with the top half of his body inside the open cupboard. He was hanging by a ligature around his neck.

52 Correctional Officers immediately called for a medical response and commenced resuscitative efforts. Interviews conducted by investigating Police with a number of Correctional Officers indicate that they all gave consistent versions. It was also clear that a number of Correctional Officers participated in the CPR efforts to revive Mr ZH. These efforts were continued until the ambulance arrived. A statement obtained from the ambulance officer by investigating Police states that the ambulance officers arrived at 7:26am on 11 August 2021 and on arrival they observed a registered nurse was conducting chest compressions. The registered nurse advised the ambulance that Mr ZH had been located hanging within the cell by staff who had cut him

down and commenced CPR. It was obvious to the ambulance officer that Mr ZH was deceased and the ambulance officer told the nurse to stop the chest compressions. The ambulance officer observed obvious ligature marks around the throat area of Mr ZH. The ambulance officer observed that Mr ZH was cold to the touch and there was no electrical activity present on the ECG which was attached to Mr ZH. Based on the clinical assessment, no medical intervention would have changed the fact that Mr ZH was in fact deceased. At 7:41am on 11 August 2021, Mr ZH was pronounced life extinct.

Investigation following the death

53 NSW Police were called and arrived on scene at around 9am on 11 August 2021. An investigation was carried out. A crime scene was established and forensically examined. All inmates were cleared from Unit 4E and interviewed. Relevant Correctional Officers were spoken to, and statements were obtained.

54 On examination of the inside of Cell 8, Police observed that the ligature around Mr ZH's neck was tied to a hang rail in the cupboard. On a desk next to the cupboard, there were pieces of fabric similar to that of the ligature. There was a calendar with the Chinese characters written across the boxes for 10 and 11 August 2021 which stated, "11 more months till release". The calendar also had quotes from the bible under each date. There was no steno phone inside the cell. Police found an ear plug in Mr ZH's left ear. Multiple horizontal lacerations were observed on his forearms, some were scabbed over, and some were relatively new, consistent with a possible self-harm incident the week prior.

55 Cell 8 was searched. A diary and a notebook were found in the cupboard and were seized. The notebook contained entries written in Chinese by Mr ZH which were messages addressed to himself in heaven. Investigating Police arranged for translation for a number of these notebook entries. A number of

the notebook entries referred to his wife cheating on him, and that she crushed him.

- The notebook entry dated 23 July 2021, was made on the day when he is also recorded as having called his mother. This entry was a letter addressed to himself in heaven. He spoke about his ex-girlfriend, who he referred to as his wife, that she cheated on him with two men and made him watch, that she was evil and cruel, and that bit by bit "they" made him a psycho, a retard and that he could not even remember what he did in the last five minutes.

- In the note of 23 July 2021 he stated:

> "death and all these stuff are real. I wish I could watch the replay of the day. When I am back home I should stay far away from….. in case people become jealous of me and then give me a hard time…. Everyone pretends to be treating me nicely, then starts to persecute me secretly. I hope I would become smarter"

- He stated in a note dated 23 July 2021 that that he would die at the age of 33 or 35 if he has intestinal cancer.

- There were two entries on 31 July 2021. The first entry of 31 July 2021, again addressed to himself in heaven, he talked about the trick his wife played on him, that a girl named CY seduced him so that his wife would have an excuse to mess around. He said that everyone hated him, that he was just a dog, but he wanted to be a human being again.

- The second notebook entry made on 31 July 2021, he wrote "one woman married to two men and gave birth to babies for them". It appeared that he was extremely disturbed by this information.

- In the note of 31 July 2021 he also stated that he had been in hell for seven years, he had been made a retard and a psycho.

56 The notes indicate a fixation on the alleged infidelity of his former wife or girlfriend – it is noted that information provided to investigating Police was unclear as to his relationship history. The notebook writings also indicate the possible presence of some persecutory thoughts, and that in the weeks prior to his death he was ruminating on things that worried him and expressing some distress.

57 CCTV footage from the single camera situated outside the entrance of Unit 4E was reviewed. Mr ZH was identified to have last entered the building at 5:18pm on 10 August 2021. Given that Unit 4E housed inmates are classified as minimum security, the level of supervision by Correctional Officers was minimal. After the evening muster, inmates were locked inside the building, but they can otherwise move freely within their floor. Each individual cell door can be locked from the inside.

58 Police interviewed a number of inmates housed in Unit 4E at the time of Mr ZH's death. He was described to be someone who was quiet, kept to himself and had no issues with any other inmates. However, the general opinion from the inmates was that Mr ZH was likely suffering from mental health issues. Most of the inmates talked about his partner's infidelity and his son who he has never met. Some of the inmates believed that Mr ZH had mistaken his release date to be July 2021 and was depressed when he realised that he still had another year in prison.

59 Some of the inmates stated that Mr ZH had put through requests to see a psychologist but was never provided the assistance. However, no such requests or self-referral forms were located in the CSNSW casefile or St Vincent's Correctional Health Records. Of note, the last case note in relation to psychology service was dated 19 February 2019, when Mr ZH declined to see a psychologist.

60 Investigating Police examined, and made enquiries, about the availability of mental health assistance to inmates at the Parklea Correctional Centre. The results of those enquiries, and the mental health services available, were

detailed and are contained in the written statement provided by Detective Senior Constable Allan. Investigating Police also noted the history of attempted interaction by psychologist services when Mr ZH was at a previous correctional facility in 2019 and that he declined to participate. There were no records of Mr ZH requesting any mental health treatment while at Parklea, nor were there any records of Mr ZH having any engagement with psychology services at Parklea.

61 Inmate BT, spoke to Correctional Officer Price on 11 August 2021. Mr BT was emotional and told Correctional Officer Price that he had been speaking with Mr ZH the previous evening (10 August 2021). Mr BT told Correctional Officer Price that Mr ZH had spoken to him about being deported after finishing his sentence, and also that his partner was cheating on him, and he was upset about these things. Inmate BT advised Correctional Officer Price that he was blaming himself for not doing more for Mr ZH. Correctional Officer Price assured him that counselling support would be offered to inmates. She then attended a debrief and provided a statement to investigating Police.

62 In a statement to investigating Police, inmate BT spoke about conversations which he had with Mr ZH. He also spoke about his conversation with Mr ZH the night before he died. That conversation included Mr ZH saying that he had thought his sentence was ending soon and he was getting out this year, but then found out it was next year. Inmate BT was also aware that Mr ZH had a parole phone call a couple of days ago but was unsure what had been told to Mr ZH during that phone call. He perceived that Mr ZH seemed to have closed down a bit after that phone call. He also told investigating Police that the night before his death Mr ZH had borrowed a fan from a cellmate. Mr BT also reported that the Mr ZH used to sleep with earplugs in, and it was not uncommon for his door to be unlocked.

63 Another inmate reported to investigating Police that Mr ZH had indicated to him that he was expecting to be released from gaol in July 2021, but he had learned the actual release date was not until July 2022. The inmate said:

> "that's put him very down, he was way expecting after six years to get out and I think that's what kicked it".

64 This same inmate also said that Mr ZH was happy residing in building for 4E:

> "he had no issue with anyone, you know, no issue"

65 Two inmates reported last seeing Mr ZH between 10pm and 10:45pm on 10 August 2021. The last Correctional Officer to see him saw him at 6:40pm on 10 August 2021.

66 Police discovered that Mr ZH had found out his girlfriend had been cheating on him and had spoken about this to other inmates; he seemed to be upset about this. He had recently not been turning up for his gaol employment.

67 Mr ZH's family and friends were spoken to, and no one was aware of him having any mental health issues. Ms LH, in particular, does not accept that he took his own life. Mr ZH seemed to speak very little about his criminal associations and never spoke about having had a son to his family.

68 Mr ZH's CSNSW casefiles and all his medical records were obtained and reviewed by Police and were reviewed as part of the coronial investigation.

69 The internal death in custody investigation conducted by CSNSW found that in relation to Mr ZH's death, the Correctional Officers responded appropriately in accordance with their procedures and that there was no evidence of third-party involvement or foul play.

70 All relevant policy and procedure documents were obtained as part of the coronial investigation, from CSNSW, Justice Health and St Vincent's Correctional Health, particularly regarding inmate mental health screening, care, and management. After review of these documents, no breaches or non-compliances were identified.

71 Audio recordings of Mr ZH's outgoing calls from 1 July 2021 were obtained and listened to. There were a number of phone calls made by Mr ZH to his

grandmother, to a friend, and one call was made to Ms LH, his mother. Various of the telephone calls were translated by investigating Police. The one call made to his mother on 23 July 2021 was translated. In that phone call Mr ZH says he hasn't been in a good mood lately with too much going on, and the ex-girlfriend being with someone else. His mother gave advice to stop worrying and that he could come back to his uncle in China for help. The last calls were made on 8 August 2021, 2 days before his death. Most of the calls were to his grandmother and to his best friend BR. Mr ZH contacted BR as often as twice a week and borrowed money, around $100 at a time. He would ask BR to deposit $10 to $20 to his prison account and the rest ($50 to $80) into various other bank accounts. By 8 August 2021, Mr ZH owed BR $1325. His grandmother had prepared $2000 to repay BR but he did not collect the money.

72 Police found that the account holders of these accounts were associated with two inmates who were also in custody at Parklea and were both known for supply of prohibited drugs. It is believed, but not positively known, that Mr ZH used these deposits to purchase prohibited drugs from these two inmates. The deposits occurred twice a month since June 2021 with the last made on 2 August 2021. BR was not aware of who he deposited the money to. On 2 August 2021, Mr ZH, when asked, told BR that these people bought him "food and stuff".

73 On 30 August 2021, Police were made aware of a Facebook post on a Facebook Page called "the Last Governor" which stated that Mr ZH was heard to have been in a heated argument just days before his death. This allegation is inconsistent with the accounts from inmates housed in Unit 4E. There was also no mention of such an incident in the statements and incident reports from all relevant Correctional Officers contained in the CSNSW casefile, nor did any inmate report this to investigating Police. Investigating Police made enquiries with the administration of the Facebook page, who stated it was a direct quote from an article published in the Daily Telegraph. Police obtained copies of the article and commenced enquiries with the relevant journalists. Police pursued those enquiries with the journalists, and received advice from

Counsel for Newscorp, Australia, that the requested information came from a confidential source and pursuant to section 126K of the Evidence Act the source of the information was declined to be disclosed. The Evidence Act provides for protection of various sources of confidential communications, and these include journalist's sources (if a journalist has promised an informant not to disclose the informant's identity, neither the journalist nor his or her employer is compellable to give evidence that would disclose the identity of the informant or enable that identity to be ascertained). While s126K(2) provides some limits on the confidentiality, on all the evidence, this report from an alleged confidential source was inconsistent with other evidence available to investigating Police and to the coronial investigation, and may well be unreliable. It is noted that none of the other inmates described hearing such an argument and indeed one of the inmates told investigating Police that area four was "laid-back" and if there had been a heated argument, other inmates would have heard about it. He further stated that Mr ZH was not argumentative and would not have been involved in an argument.

Cause of death

74 A full coronial postmortem examination was conducted and found the cause of Mr ZH's death was hanging. The Autopsy report noted multiple healing, parallel, linear crusted wounds on the forearms bilaterally. These appeared to be previous self-harm attempts. Otherwise, no external or internal injuries were identified. The toxicological analysis detected no drugs, medications, or alcohol in Mr ZH's system.

75 The Officer-in-Charge, Detective Senior Constable Allan, arranged for communications with Mr ZH's mother in China. She also received advice that the mother of Mr ZH had communicated with the Department of Forensic Medicine and the New South Wales Coroners Court that she believed her son had been murdered and had a broken neck. Investigating Police made a number of enquiries, including having discussions with the pathologist. The pathologist advised investigating Police that Mr ZH did not have a broken neck but did have a small fracture in the thyroid cartilage (around the Adams

Apple area) which is not inconsistent with the hanging. The other injuries to the deceased were the healing cuts to his arms which appeared to be previous self-harm attempts, and there were no defensive injuries present to indicate any third-party involvement in the hanging.

76 Police identified no suspicious circumstances surrounding Mr ZH's death. The Officer-in-Charge believed Mr ZH may have suffered from some undiagnosed mental health conditions, namely depression, given that he appeared to have committed self-harm in the weeks prior to his death by cutting his arms. The investigating Police also noted that Mr ZH's behaviour had changed, as reported by other inmates, in the weeks leading up to his death. His changed behaviour was also objectively demonstrated by Mr ZH not attending work at the Correctional Centre, for previously he was described as a good worker. On the evidence, the investigating Police officers were of the opinion that Mr ZH has cut a piece of his inmate issued blanket, possibly using the blade from a disposable razor, and has used this to hang himself from the clothes-hanging rail in the cupboard which was located in his cell.

Issues raised by Mr ZH's mother

77 Ms LH, Mr ZH's mother, raised the following issues with the Coronial Advocate Assisting the Coroner.

78 Ms LH is of the firm belief that Mr ZH did not commit suicide and that his death should be treated as suspicious based on:

(1) There was no reason for Mr Zhang to take his own life because:

(i) He was about to be released soon (that his sentence of imprisonment was about to come to an end), after being in custody for many years

(ii) He cherished his life, and would not hurt himself in the slightest

(iii) He has a promising future, where everything has been planned for him upon his release and return to China, that he was young and handsome, there would be no issues for him to start over with a job and a family

(iv) The last time she spoke to him, he was in good spirits, and everything was fine

(2) Ms LH believes that Mr ZH's death was caused by someone else because:

(i) His cell door was not locked which is inconsistent with someone who intended to suicide

(ii) Someone has fed him the information about his ex-girlfriend on purpose with malicious intent

(iii) There was no CCTV or any Correctional Officers inside Unit 4E so that the movements in and out of Mr ZH's cell by a potential assailant would not be detected

(iv) The theory of Mr ZH being killed first before being placed in the position he was found is a real possibility

(v) Mr ZH's criminal associates were still able to taunt him and communicate with him

(vi) She understood that Mr ZH had a "fractured neck bone" and saw photos of Mr ZH where his tongue was not sticking out which she believes were not suggestive of suicide

79 However, for reasons detailed below, the weight of evidence supports a finding that Mr ZH hanged himself with intention to self harm. The evidence showed that Mr ZH was under a combination of mental and emotional stress

factors which would have contributed to his actions to take his own life, and these include the following:

80 It was Mr ZH's clear intention to remain in Australia, at least for the duration of his parole which would not expire until 2 October 2024. He had nominated to stay with his grandmother whilst serving parole. He planned on continuing to work to help his family financially. However, he did not have the legal immigration status to remain in the community, as his permanent residency was cancelled and his Bridging Visa only provided him with Visa status whilst in custody. He was concerned about the uncertainty of his future which was far from being "all planned out". This was a mental stressor for Mr ZH as he would have to serve his parole in immigration detention rather than in the community.

81 As detailed above the evidence indicates that in July 2021 Mr ZH realised that he had misunderstood the situation regarding his release – the date of his earliest release on parole being a further 12 months away in July 2022. He also appeared somewhat confused about his eligibility for re-classification to C3; and whether if he would be released to the community or held in immigration detention. The realisation of his later release date, the uncertainty of his status with classification and, eligibility for work release given his Visa status, would have contributed to his mental and emotional stress.

82 Mr ZH was still struggling with his drug addiction. He was disciplined multiple times throughout his time in custody, and was recorded to have used drugs while in custody. In April 2021, Mr ZH marked his calendar with the words "I won't smoke, wont smoke". He was eligible to participate in the Intensive Drug and Alcohol Treatment Program, but he ultimately declined to participate. On 6 August 2021, during the interview with Parklea Parole Service, Mr ZH was heard to slur his speech and became incomprehensible. He also borrowed money from his friend which was deposited into nominated accounts whose holders were associated with inmates known for supply of prohibited drugs. The evidence suggests substance abuse was still a problem for Mr Zhang.

83 Mr ZH's own health, the diagnosis of colitis and the continued suffering from his bowel issues would have also added to his mental stress. However, he does not go through with the proper treatment as recommended. He wrote in his notes that he will die of "intestinal cancer".

84 The evidence also indicates that Mr ZH experienced distress over the following issues:

- Knowing that his friends all moved on with their lives whilst he spent the last 7 years in "hell"
- Not having family around him and his grandmother's deteriorating health
- Grieving for the deaths of his father in 2012, his grandfather in 2013 and his aunty in 2015
- Being informed of/preoccupied with his ex-girlfriend's infidelity
- Realising that he would have to spend another 11 months in gaol, the possibility of spending time in immigration detention beyond that, and the possibility of eventual deportation back to China

85 All these stressors, and uncertainties regarding his future, and his health difficulties, were factors weighing on Mr ZH's mood, and impacting his mental health. That his mental state suffered is evidenced by the physical evidence of his previous self harm attempts, including as recently as one week before his death.

86 Regarding Ms LH's belief that Mr ZH had a broken neck bone, this was likely a misunderstanding which would have originated from the mention in the autopsy report of a "non-fusion of the body and right greater horn of Mr ZH's hyoid bone". The Forensic Pathologist clarified and confirmed that autopsy findings did not indicate that Mr ZH had a "broken neck" but rather a small

fracture in the thyroid cartilage (around the Adams apple area) which is not inconsistent with hanging.

87 The postmortem examination also did not identify any suspicious internal or external injuries - apart from the ligature mark which was consistent with the hanging and the ligature; and the healing lacerations on Mr ZH's forearms which were consistent with his recent self-harm attempts. No defensive wounds or traumatic injuries were observed, and as such there was no evidence of anyone but Mr ZH being involved in the hanging. The toxicological results did not detect any substances.

88 The ligature mark was also directly above the thyroid prominence. The pattern of lividity was consistent with the posture in which Mr ZH was found.

89 Further to the Autopsy findings, despite the lack of CCTV footage inside the unit, the Police crime scene examination and search of Mr ZH's cell did not identify any suspicious circumstances or traces of third-party disturbance at the scene. There was no evidence, both forensically and physically, that suggested his body was moved after his death. All of the 13 inmates housed in the same unit as Mr ZH were questioned and interviewed immediately after his death. No inconsistencies were identified and none of these inmates had any motivations to cause harm to Mr ZH.

90 Whilst we may never know for sure why Mr ZH chose to leave his cell door unlocked, the evidence suggests that he may not have had a habit of locking his cell door at night. Inmates interviewed stated that Mr ZH would often not wake up in time for the morning muster. Mr ZH also had a habit of sleeping with ear plugs and may not hear the mustering call. Other inmates would often open Mr ZH's cell door before or during morning muster to wake him up before the Correctional Officers could reprimand him for being late to the muster.

91 There is no evidence supporting any finding of third-party involvement in Mr ZH's death. For the foregoing reasons, the evidence supports the conclusion that Mr ZH's death by hanging was self-inflicted.

Other issues

92 Other issues identified during the coronial investigation included:

- The existence of hanging points in the wardrobe inside the cells
- The lack of presence of and intervention by Correctional Officers
- The absence of CCTV cameras inside the buildings, and the absence of duress alarms inside individual cells
- The lack of mental health care and the lack of early prevention of self-harm by Mr ZH
- The need for more mental health counsellors

93 Enquiries have been made with Parklea Correctional Centre, Correctional Services NSW, Justice Health and St Vincent's Correctional Health. These issues can be appropriately addressed with the responses received.

94 In relation to the existence of clothing hang rails in wardrobes of minimum-security cells, and their potential use as hanging points, it was explained that general-purpose cells within Correctional facilities similar to the one which housed Mr ZH, are not considered as anti-ligature cells. The design of the minimum-security facility at Parklea Correctional Centre was risk assessed in consideration of the minimum-security classification of the proposed inmates. The risk assessment found the design, as built, to be appropriate, and in consideration of risks such as the subject ligature point, these risks are mitigated through the appropriate assessment of inmates that receive the minimum-security classification. The design of wardrobes in the cells are also

modelled to provide the inmates with a sense of normalcy to assist them with easy transition back into community upon release.

95 In relation to absence of Correctional Officers patrolling overnight, there is a similar rationale based on the fact that the accommodation unit where Mr ZH was housed, was a minimum-security facility for inmates who were appropriately classified. In order to promote the sense of normalcy and prepare the inmates for easier transition into the community upon release, a minimal level of supervision is deemed to be appropriate. In such facilities less reliance is placed on CCTV cameras and constant presence of Correctional Officers due to inmates' lower security classification.

96 The security setup at minimum security facility at Parklea - lack of CCTV monitoring the inside of the block, and lack of intercom/stenophones in individual cells may be problematic when it comes to the early detection/prevention of harm to inmates, whether self-inflicted or by others, as it relies heavily on reports by inmates or coincidental observation by health or correctional staff. Installation of additional CCTV cameras inside the accommodation unit may improve accountability and safety of inmates in environments where the constant presence of Correctional Officers is not required. However increasing the level of video surveillance for minimum security inmates who are classified as low risk, and some of whom have work release in the community may work against providing normalcy for community transition.

97 In relation to the mental health services available at Parklea Correctional Centre, and the issue raised regarding the quality and extent of the care and management provided, the following information was provided which goes towards addressing these issues:

- Nurse-led primary mental health clinics are provided by St Vincent's Correctional Health at the Parklea Correctional Centre, which operate 7 days a week, with a Mental Health Nurse practitioner 5 days a week and a psychiatrist available 4 days a week

- St Vincent's Correctional Health provides a qualified Mental Health Nurse 24 hours a day 7 days a week to assess and manage custodial patients who are referred or deemed at risk

- One 0.8 full time equivalent psychiatrist, one full time Mental Health Nurse practitioner and 10 mental health nurses are employed to provide mental health care and services at Parklea Correctional Centre, whilst MTC Broadspectrum provides psychologists

- Inmates also have access to the Mental Health Helpline which is a 24/7 free phone service that provides professional mental health advice, supportive counselling and referral to the most appropriate service, by experienced mental health clinicians

- Inmates with mental health risks can be identified via reception screening, return from court reviews, mental health reviews, self-referrals, walk-in reviews, and staff and external referrals

- Mental health screening is also mandatory as part of the comprehensive reception screening assessment

98 However, the ease of access to mental health services in practice is difficult to judge. In relation to this inquest into the death of Mr ZH it appears to have not contributed to his circumstances, as the evidence indicates no mental health services were requested by Mr ZH or provided to him at Parklea. Whilst there were concerns for his general mental health, there is no record of any notification of any risks of self-harm or suicide identified or expressed by Mr ZH, or notified to custodial authorities or mental health clinicians by anyone else while Mr ZH was in Parklea. Despite the relevant procedures and services already in place, Mr ZH's previous act of self-harm was only witnessed by one other inmate who did not report it to the authorities. There was otherwise no detection of the incident by any Correctional Officers or St Vincent's Health staff.

99 According to the records at Parklea, there were no self-referrals submitted by Mr ZH for mental health assistance during his time at Parklea Correctional Centre.

100 The evidence indicates that Mr ZH had a seemingly poor ability to describe his own issues, and a reluctance to disclose and address mental or emotional stressors in his life. He also showed some lack of engagement with his physical health issues, as detailed above. There is evidence that he also undertook deliberate actions to avoid detection, by wearing long sleeves to hide his self-harm wounds, all of these aspects made it difficult for detection and prevention of self-harm attempts or risks.

Whether any recommendations required pursuant to s82 of the Coroners Act

101 On the evidence in this matter there are no recommendations to be made. Applicable policies were not identified to be deficient or requiring change, as detailed above. I also note that there is currently a commitment within the Justice Health and Forensic Mental Health Network to prevention of suicides in custody. As noted in findings made in another inquest, (Inquest into the death of Mr WW, 2021/00263382, findings delivered 4 July 2022) the Health and Forensic Mental Health Network has developed a Position Paper: "Suicide Prevention in Custody". It was recorded in the findings for that inquest that:

> 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.

102 Given this project is underway, and noting the evidence in this matter, as detailed above, then I am satisfied that there are no recommendations to be made.

Findings under s81 of the Coroner's Act:

103 For all the above detailed reasons I make the following findings:

Identity: ZH

Date: Between 11pm on 10 August 2021 and 7:41am on 11 August 2021

Place: Cell 8 of Unit 4E Lower Ground at the Parklea Correctional Centre

Cause: Hanging

Manner: Self-inflicted

Closing

104 I acknowledge and express my gratitude to the Coronial Advocate assisting the Coroner, Mr Kai Jiang, for his assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Penelope Allan, for her work in the Police and Coronial investigation and compiling the evidence for the inquest.

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

106 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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Annexure A – Non Publication Order 1

1. Under section 74(1)(b) of the *Coroners Act 2009* (NSW) (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published as it is information that is not available to the public and, if released, has the potential to jeopardise Corrective Services New South Wales (**CSNSW**) and Management & Training Corporation Pty Ltd and Ventia Australia Pty Ltd (**MTC-Broadspectrum**) security arrangements and the safety of staff, inmates and visitors:

    a. names, Visitor Index Numbers, addresses, phone numbers and other personal information that could tend to identify ZH's family, friends and visitors (other than legal representatives or persons acting in a professional capacity);

    b. the direct contact details of CSNSW staff that are not publicly available;

    c. names, personal information and Master Index Numbers of any persons in the custody of CSNSW or of MTC-Broadspectrum other than ZH;

    d. CCTV footage and any stills of that footage and handheld video camera (**HHVC**) footage;

    e. information that discloses the limitations in CCTV footage as identified in the Schedule attached to these orders;

    f. maps of Accommodation Areas of Parklea Correctional Centre contained in Tab 64 of the brief of evidence;

    g. the Parklea Correctional Centre Daily Operational Rosters contained in Tab 65 of the brief of evidence;

h. portions of the Custodial Operations Policy and Procedure documents which are restricted to the public as identified in the Schedule attached to these orders; and

i. the MTC-Broadspectrum policy documents which are restricted to the public as identified in the Schedule attached to these orders.

2. 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 the Act for access to CSNSW or MTC-Broadspectrum documents on the Court file, that material shall not be provided until the Commissioner of CSNSW and/or MTC-Broadspectrum has had an opportunity to make submissions in respect of that application.

SCHEDULE

Tab	Relevant portion of document
Tab 34	Statement of Correctional Officer Michael Mandryk (25 August 2021) • Final two sentences of [6] (page 2) • Images A to G (pages 3 to 9)
Tab 50	CSNSW Serious Incident Investigation Report (11 August 2021) • Two images on page 14 • Two images on page 15
Tab 56	COPP 13.1 Serious Incident Reporting (version 1.3) • At [2.5] on page 5: telephone numbers (2) of the duty officer and after-hours duty-officer • At [2.6] on page 6: email address of the Custodial Corrections Branch • At [3.1] on page 7: telephone number of duty officer • At [4.1] on page 9: email address of the Custodial Corrections Branch COPP 13.3 Death in Custody (version 1.7) • At [2.4] on page 6: third sentence • At [6.1] on page 12: telephone number of the Aboriginal Strategy and Policy Unit COPP 13.8 Crime Scene Preservation (version 1.1) • At [4.1] on pages 10-11: whole sub-section except for third paragraph on page 10 and first sentence on page 11 MTC-Broadspectrum 4.12 Video Evidence (2 March 2021) (contains tracked changes) • Whole document MTC-Broadspectrum 9.05 Death in Custody (1 March 2021) • Whole document MTC-Broadspectrum 9.16 Medical Emergency (1 March 2021) (contains tracked changes) • Whole document MTC-Broadspectrum 9.19 Serious Incident Reporting (1 March 2021) (contains

	tracked changes) • Whole document
Tab 64	Map of Accommodation Area 4 at Parklea Correction Centre • Whole document (2 pages)
Tab 65	Parklea Correctional Centre Daily Operational Roster (10 August 2021) • Whole document (2 pages) Parklea Correctional Centre Daily Operational Roster (11 August 2021) • Whole document (2 pages)
Electronic document	Video recording of cell search
Electronic document	CCTV footage outside Accommodation Unit 4E at Parklea Correctional Centre, Handheld Videos of the incident produced by CSNSW