CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Trevor Samuel
Hearing dates:	28 February – 3 March 2022
Date of findings:	21 September 2022
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody – whether cause of death can be ascertained – whether the Justice Health and Forensic Mental Health Network provided adequate care and treatment.
File number:	2021/60334
Representation:	Counsel Assisting the inquest: Dr P Dwyer of Counsel i/b NSW Crown Solicitor. Trevor Samuel's family: S Crellin and S Rees, Aboriginal Legal Service. Justice Health and Forensic Mental Health Network: P Rooney of Counsel i/b Makinson d'Apice Lawyers. Commissioner, Corrective Services NSW: K Llewellyn of Department of Communities and Justice, i/b the Commissioner of Corrective Services Dr R Reznik: S Beckett of Counsel i/b J Kamaras, Avant Law. Registered Nurses M Woods and S Pukk: B Haider and J Yeung, NSW Nurses and Midwives Association.

Findings:	**Identity** The person who died is Trevor Samuel. **Date of death**: Trevor Samuel died on 2 March 2021. **Place of death**: Trevor Samuel died at Long Bay Hospital, Malabar NSW. **Cause of death:** Trevor Samuel died as a result of hyponatraemia due to excessive consumption of water, against a background of psychogenic polydipsia and treatment resistant schizophrenia. **Manner of death:** Trevor Samuel died of natural causes, at a time when he was an involuntary patient at Long Bay Correctional Centre Hospital.
Recommendations	**Recommendation 1** To the Minister of Health NSW: That the Minister of Health NSW have regard to these findings, and the statement of Associate Professor Ellis (attached), in considering allocation of funding to ensure that prisoners who require a secure mental health bed are treated in a forensic hospital, rather than in prison cells. **Recommendation 2** To the Commissioner of Corrective Services, NSW*:* That the Commissioner consider implementing appropriate and continuing mental health training for correctional officers working in Long Bay Hospital.

Non-Publication Orders

Orders prohibiting publication of certain material pursuant to section 74(2)(b) of the *Coroners Act* 2009 (NSW) [the Act] have been made in this inquest*.*

Copies of the orders can be found on the Registry file.

Introduction

1. Section 81(1) of the *Coroners Act 2009* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Trevor Samuel. Mr Samuel's family has asked that in these findings I refer to him by his first name.

3. Trevor was aged 35 years when he died in his prison cell on 2 March 2021. An inquest into the circumstances of his death is mandatory. This is because as a prisoner, Trevor relied on authorities to provide for his health and welfare. In these circumstances an inquest is required to determine whether authorities have discharged their duty of care to him.

Trevor's life

4. Trevor Akimiller Samuel was a member of a large family who love him and miss him. On behalf of his family, Trevor's older brother Tyson attended each day of the inquest with his wife Belinda. At the close of the evidence Tyson Samuel shared loving memories of growing up with his brother.

5. Trevor was a Worimi and Iama (Yama) man, and thus had both Aboriginal and Torres Strait Islander heritage. His mother Gai Buckshiram, who sadly passed in 2019, grew up in the Worimi area of Foster on the NSW mid north coast. His father Elimo Samuel was born on Iama Island (also known as Yama Island and Turtle-backed Island), about 100km northeast of Thursday Island in the Torres Strait.

6. Trevor was one of seven children, the other children being his sisters Jasmin, Florence and Brook and his brothers Tyson, Elroy and Eric. During Trevor's childhood and teenage years the family lived in the NSW country town of Tullamore in the area of Parkes, and then in Parkes itself.

7. When he was fifteen years of age Trevor left high school. He had suffered bullying due to his delayed speech, and this led to anxiety and depression, and the use of cannabis and alcohol. Nevertheless he was very good at sport and represented his school and other teams in league and union football.

8. After leaving school Trevor worked on farms and in shearing sheds. He had a relationship with Ricky Lee Dargan and the couple had a daughter Karleigha, born in 2013. A second daughter Gracie was born in 2018 from a later relationship with Linnie Beck.

9. Trevor's family remember him as a fun-loving boy and man, who had a cheeky smile and loved playing practical jokes. But Tyson knew that despite this, Trevor suffered mental illness which was complicated by substance misuse. His complex mental illnesses contributed to recurrent criminal offending, which saw him imprisoned for significant periods in his adolescent and adult life. Tyson spoke of his sadness at realising, when Trevor was still a very young man, that prison had become '*the new place you called home'*.

10. Trevor's family, like many Australians, feel deep distress at the very high numbers of First Nations people who are in custody. The 1991 report of the Royal Commission of Inquiry into Aboriginal Deaths in Custody made recommendations aimed at addressing the disproportionate numbers of First Nations people who were dying while in prison. As noted by the Commissioners in that report, the over representation of First Nations people in custody '*provides the immediate explanation for the disturbing number of Aboriginal deaths in custody'*. Thirty years later we have no reason to suppose those numbers will fall.

11. Trevor's family are also distressed that so many people with serious mental illnesses are living within the punitive environment of jails. They are deeply saddened that Trevor spent so much of his short life in jail, alone and isolated from his family. They want to see a better way of caring for mentally unwell people. At the inquest Tyson said:

> *'… if we are to care for vulnerable Aboriginal/Torres Strait Islander people with complex medical and mental health conditions in a prison system, how can we do this better? … We truly hope through this process that people realise there needs to be a massive change …'...*

12. The adequacy of mental health care for prisoners is a matter of concern for NSW coroners, and has been the subject of examination in many recent inquests. It is once again an issue for examination in the present inquest.

The issues at the inquest

13. The first issue at the inquest was whether the cause of Trevor's death could be established. An autopsy performed by forensic pathologist Dr Jennifer Pokorny could not ascertain the cause of Trevor's death, to the level of medical certainty.

14. The second main issue was whether Trevor received adequate care for his complex mental health conditions while he was in prison.

15. Trevor had been diagnosed with schizophrenia since his teenage years. In association with schizophrenia he suffered a psychiatric condition known as psychogenic polydipsia. This condition, which is further described below, is characterised by excessive drinking of water which leads to low sodium levels, or hyponatraemia. This in turn can lead to severe metabolic disturbance, collapse and death.

16. Providing custodial care to patients like Trevor with complex psychiatric conditions presents significant challenges. The inquest heard expert evidence as to whether the custodial care which Trevor received was adequate. Relatedly, the court also heard evidence as to whether the existing model of custodial mental health is able to meet the needs of prisoners like Trevor who suffer severe and intractable mental illness.

17. In examining this issue the court was assisted by expert psychiatric evidence from Dr Danny Sullivan, forensic psychiatrist and Executive Director of Clinical Services

at the Victorian Institute of Forensic Mental Health. Dr Sullivan has many years' clinical experience working in prisons and forensic hospitals.

18. In addition the court was greatly assisted with evidence from:

- Dr Robert Reznik, Trevor's treating psychiatrist during his last months. Dr Reznik is a consultant psychiatrist, and has been providing psychiatric services to prisoners for many years

- Dr Sarah-Jane Spencer, Clinical Director of Custodial Mental Health and Medical Superintendent of Long Bay Hospital

- Associate Professor Andrew Ellis, Senior Staff Forensic Psychiatrist, and Clinical Director of the Forensic Hospital, Malabar.

19. The above psychiatrists have many years' experience providing mental health care in NSW correctional centres. Their experience lends significant weight to the evidence they gave at the inquest.

20. As will be seen, in this inquest I have found that the psychiatric care provided to Trevor within the Long Bay Hospital was adequate, and that the doctors and nurses who treated him were competent and generally compassionate people.

21. However, this assessment is made against the background of what psychiatric care is available within a prison hospital. In this inquest, as in many others which this court has conducted, the expert psychiatric evidence was unanimous: for prisoners with severe and enduring mental illness, a prison hospital is not able to provide the level of care which is required. Prisoners like Trevor who suffer severe and complex mental illness need to be treated within the therapeutic environment of a secure forensic hospital.

22. Yet the evidence at inquest was that bed capacity within Malabar's Forensic Hospital is very limited, and its waitlist is long. This evidence provides an ample basis for one of the recommendations which I will make in this inquest, that the Minister of Health consider allocation of funding to ensure that prisoners who require a secure mental health bed are treated in a forensic hospital, rather than in prison cells.

The events of 2 March 2021

23. I will briefly describe the undisputed facts surrounding Trevor's death.

24. On 18 September 2020 Trevor was charged with domestic violence related offences. At this time he was on parole for previous offences. His parole order was revoked, and he was directed to serve the remaining nine months of his parole in custody. Due to his severe mental illness, Trevor spent much of this final incarceration as a scheduled patient in the Mental Health Unit of Long Bay Hospital [LBH].

25. LBH is situated on the Long Bay Correctional Centre campus. It is operated by correctional officers, with health care largely supplied by employees of the Justice Health and Forensic Mental Health Network [the JH Network]. Mental health care for inmates is supplied by Custodial Mental Health [CMH], a specialty service within the JH Network.

26. Trevor was housed within LBH's G Ward. This is a unit of 20 single cells, ten of which were monitored by camera on a 24 hour basis. Conditions within G Ward are highly restrictive. Patients on G Ward receive a one hour exercise period each day, but are otherwise confined to their cells. On days when staffing levels permit, they may receive an extra hour of exercise.

27. On 2 March 2021 Trevor had just commenced a three-day period of segregation. This disciplinary measure had been imposed after he spat at psychiatric registrar Dr Natalya Godbold the previous day.

28. Under segregation conditions, Trevor was permitted only the mandatory one hour exercise period per day. For the remaining 23 hours he was confined to his cell, with all interactions conducted through the hatch of his closed cell door. This included his consultations with his psychiatric treating team.

29. On the morning of 2 March 2021 Trevor was given breakfast by Correctional Officer Deniz Cecen. Officer Cecen was accompanied by a JH Network nurse who gave Trevor his medication. Shortly afterwards, Registered Nurse Marie Claire Woods heard the sound of the shower on in Trevor's cell.

30. Later that morning Trevor was reviewed by his treating psychiatrists, Dr Reznik and Dr Godbold. Their impression was that Trevor's psychosis was worsening compared with the previous week, and that he was more thought disordered.

31. At about 12.15pm, Correctional Officer Cecen gave Trevor his lunch. Forty minutes later, RN Woods carried out visual observations of the G Ward patients. She looked into Trevor's cell and saw that he was lying face down on the floor. She could not see movement of breathing, and when she called his name he did not respond.

32. RN Woods immediately raised the alarm, collected an emergency bag and defibrillator, and obtained access to Trevor's cell. Correctional officers came with her. They commenced chest compressions, while Officer Cecen held the oxygen mask to Trevor's face.

33. JH Network doctors arrived to assist with the resuscitation attempt. An ambulance had been called when the alarm was raised, and it arrived at 1.14pm. Despite the efforts of the ambulance officers, Trevor could not be revived. He was pronounced deceased at 1.30pm.

34. At the inquest it was not suggested that there were any deficiencies in the emergency response to Trevor's collapse, despite the tragic outcome.

The cause of Trevor's death

35. The autopsy report into Trevor's death was not able to establish the cause of his death, to the level of medical certainty. This was despite a thorough autopsy examination including biochemical and blood testing, and an examination of Trevor's brain by a specialist neuropathologist.

36. Forensic pathologist Dr Jennifer Pokorny was aware that Trevor suffered from psychogenic polydipsia, and she was looking for signs which might indicate the presence of hyponatraemia. As part of the autopsy, vitreous fluid from Trevor's eyes was analysed for levels of sodium. These proved to be very low, at 110mmol/L. However vitreous sodium levels are known to decrease after death. Therefore it was not possible for Dr Pokorny to determine whether Trevor's sodium levels had been low just before he died, or whether they had been normal but had decreased after his death.

37. In her autopsy report Dr Pokorny made the following observations:

- Trevor did not have any injuries, other than scarring on his forearm suggestive of previous self harm, and bruising and abrasion to his lips which was likely the result of the medical attempt to resuscitate him.

- Trevor's brain was generally swollen, which is consistent with low sodium levels. However a specialist neuropathologist had found no evidence of central pontine myelinolysis, a change that can be seen with rapid correction of low sodium levels.

- Approximately 500ml of watery fluid was found in Trevor's stomach, a larger quantity than is normally found after death.

38. Dr Pokorny concluded that the cause of Trevor's death remained unascertained.

39. However in her oral evidence at the inquest, Dr Pokorny told the court that it was '*more likely than not'* that Trevor had died as a result of hyponatraemia. Many of the features she had identified at autopsy were consistent with this condition, and none were inconsistent with it. Furthermore there were no signs of other causes of death, such as epileptic seizure disorder or heart disease.

40. It is relevant to note that on the morning of Trevor's death the water had been switched on in his cell. He therefore had access to water in the hours leading up to his death. Furthermore according to Dr Sullivan, it is common for hyponatraemia to have a rapid onset following consumption of a very large quantiy of water.

41. The above evidence, together with Trevor's medical history, enable me to find on the balance of probabilities that Trevor died as a result of hyponatraemia caused by excessive water consumption.

42. I turn now to describe Trevor's psychiatric conditions, and the treatment he received in prison for them.

The condition of psychogenic polydipsia

43. I have noted that Trevor suffered both schizophrenia and psychogenic polydipsia. Psychogenic polydipsia is characterised by excessive drinking of water. This causes a person's levels of sodium to become diluted, leading to metabolic disturbance, delirium, seizures and collapse. Throughout his life Trevor had been hospitalised a number of times after collapsing due to critically low sodium levels.

44. For much of his time in custody it was recognised that Trevor was mentally unwell with schizophrenia and psychogenic polydipsia. Because psychogenic polydipsia is a potentially life-threatening condition, Trevor was often subject to assertive interventions in custody. His prison management plans generally involved weekly blood tests to monitor his sodium levels, monitoring his fluid intake, and turning off the water supply to his cell when he showed signs of water intoxication.

45. As to why Trevor felt compelled to drink excessive amounts of water, at the inquest Dr Sullivan commented that there appeared to be a delusional basis for this. At times, Trevor had voiced to his treatment team a fixed belief that passing large amounts of water would help him to manage his weight.

46. Complicating Trevor's difficulties was the fact that his schizophrenia was largely treatment resistant. Despite being prescribed with different types of antipsychotic medication over the years, none of these were particularly effective in reducing his psychotic symptoms. As a result, Trevor was never able to achieve significant periods of mental stability.

47. This had very adverse consequences for Trevor and no doubt for those around him. Trevor's treating psychiatrist Dr Reznik considered that Trevor's assaultive behaviours, which were a feature of his criminal offending, were associated with the paranoid and delusional beliefs he suffered as a consequence of his schizophrenia.

The psychiatric care provided to Trevor

48. I will now outline the psychiatric care which Trevor received in the months leading up to his death.

49. In October 2020 Trevor came under the care of consultant psychiatrist Dr Robert Reznik. Dr Natalya Godbold also worked with Trevor, as Dr Reznik's psychiatric registrar. At that time she was on a six month placement at LBH.

50. Dr Reznik first reviewed Trevor on 20 October 2020. He noted Trevor's history of treatment resistant schizophrenia, psychogenic polydipsia, substance misuse and likely intellectual impairment. He commented that Trevor's behaviour was '*characterised often by impulsive self harm, and aggression',* and that he appeared to have *'... no insight into his mental illness and the danger of his drinking water.'*

51. Dr Reznik personally reviewed Trevor on multiple occasions between 10 November 2020 and 2 March 2021, sometimes accompanied by Dr Godbold. At regular intervals Dr Reznik also reviewed Trevor's management plan. Throughout

this time he found that Trevor remained psychotic, with very little understanding either of his schizophrenia or his polydipsia.

52. An important element of Dr Reznik's treatment plan for Trevor consisted of weekly blood tests to monitor his sodium levels. When Trevor's sodium levels dropped below 125 mmol/L, Dr Reznik directed that his access to water be restricted to twelve hours during the day. During those periods, nursing staff were instructed to turn off the water supply to Trevor's cell at night time.

53. Dr Reznik and Dr Godbold attempted to counsel Trevor about the physical dangers of his excessive water drinking. However Dr Reznik explained that for patients like Trevor, their psychotic symptoms make it almost impossible for them to listen to and engage with their therapist. For this reason, at the commencement of 2021 Dr Reznik was considering adding the mood stabiliser olanzapine to Trevor's medication. He hoped that with some reduction of his psychotic symptoms, Trevor might be able to understand the risks imposed by his condition and choose to make changes himself.

54. In January 2021 Dr Reznik assessed that although Trevor remained psychotic, his behaviour had become more settled. With this small improvement, Dr Reznik felt able to transfer Trevor to the less restrictive environment of LBH's F Ward.

55. But on F Ward Trevor's psychosis and fluctuating hyponatraemia continued, and on 18 February 2021 correctional officers expressed concern to Dr Reznik about threats Trevor had made to them. Dr Reznik raised this with Trevor, and gave this discouraging account of their consultation:

> *' … he initially engaged, then became hostile*, *aggressive – spat at me, resulting in termination of the review. … He remained totally insightless. The plan was to offer olanzapine which he refused. He was therefore to be transferred back to G Ward.'*

56. Back in G Ward, throughout February 2021 Trevor's episodes of hyponatraemia continued. Dr Reznik was concerned, and he directed correctional officers and JH Network staff that there was to be '*a low threshold'* for Trevor to be referred to an Emergency Department for treatment.

57. On 1 March 2021 Dr Godbold reviewed Trevor. As he frequently did, Trevor asked her when he could be released from prison. She replied that they would need time to work towards his discharge, upon which Trevor spat at her and the review came to an end.

58. Dr Reznik and Dr Godbold reviewed Trevor the next day, which was 2 March 2021. Trevor apologised to Dr Godbold for spitting at her the previous day. She recorded that he appeared calm and relaxed '*with good eye contact and some warmth'*. However both doctors thought that his psychosis was worsening. He remained thought disordered and delusional, telling them that he had discovered a code '*which can make the whole world speak English'*. Dr Reznik decided to commence Trevor on depot injections of olanzapine the next day.

59. However this did not happen as tragically, Trevor died later that day.

Dr Sullivan's opinion of Trevor's care

60. Dr Sullivan was asked to provide his expert opinion as to whether Trevor's condition of psychogenic polydipsia was appropriately managed while he was in custody.

61. In his expert report and evidence, Dr Sullivan stated that the management of Trevor's mental health in his final period of incarceration was '*overall, appropriate'*. I note that after writing his report Dr Sullivan was provided with further records. These caused him to reverse his earlier opinion that there was little evidence of regular psychiatric assessment or of long term treatment planning

62. In Dr Sullivan's opinion Dr Reznik's management plan for Trevor's polydipsia was appropriate. It involved '… *restriction to fluids and monitoring of fluid balance, as well as regular testing of sodium levels'.* These measures reduced the risk that Trevor would manage to harm himself with his fluid intake. Dr Sullivan was further of the view that the medications which Dr Reznik had prescribed for Trevor were appropriate.

63. Dr Sullivan was conscious that the management plan for Trevor imposed profound restrictions on his autonomy and quality of life. He commented that such restrictions on a patient's rights and liberty were only really possible within a custodial setting, due to:

> *' … its capacity to isolate a person in a cell and restrict access to fluids by turning off the plumbing to a cell. It is hard to imagine other settings in which such restrictions could be imposed both effectively and within legal parameters'*.

64. In other words, within a prison setting staff were largely able to protect Trevor from the dangers of excessive water drinking, with extreme measures which removed almost all aspects of his autonomy.

65. All those who treated Trevor recognised that these measures were detrimental to his psychological health and wellbeing. Dr Reznik was visibly distressed as he told the court that Trevor was *'in the poorest of situations'* and that he often felt like he was *'treating him like an animal'*. When he commenced caring for Trevor he had hoped to build a therapeutic relationship with him, whereby Trevor would eventually choose to make changes himself. Sadly, this goal was never attained.

66. Dr Reznik's further hope and plan was that when Trevor became due for release in June 2021, he could be transferred to the adjacent Forensic Hospital. In that more therapeutic environment, Trevor might have been persuaded to commence oral clozapine, and so gain better control of his psychotic symptoms. This in turn would allow him to gain some degree of autonomy over his own life.

67. Later in these findings I will describe the approach to psychiatric treatment adopted in the Forensic Hospital, and whether it would have been a more appropriate environment within which to treat Trevor's illnesses.

Conclusion regarding Trevor's psychiatric care

68. Although Dr Reznik was unable to develop a therapeutic relationship with Trevor, it is clear that he tried to do so and that he empathised with Trevor's situation. He considered Trevor's aggressive behaviour, including his spitting, to be a manifestation of his extreme frustration at his restrictive situation.

69. Similarly, Dr Godbold told the court that when Trevor spat at her on 1 March 2021 she '*didn't take it personally'*, regarding it as an expression of his extreme powerlessness. She observed that he had '*no power at all – not even to have a shower without asking'.*

70. The comments of both doctors illustrate the difficult task they had in balancing Trevor's physical safety with the effect on his mental health of measures which removed freedom and dignity from his life. Added to this was the very considerable challenge of providing him with psychiatric care within a custodial environment, a topic to which I will return.

71. Dr Reznik impressed as a capable and compassionate psychiatrist. It was evident that he cared about Trevor, and that he felt distress that he was unable to keep him safe from the effects of his polydipsia without profound compromise to his rights and dignity as a human being.

72. I accept Dr Sullivan's assessment that the care which Dr Reznik provided to Trevor was adequate and appropriate. The evidence also indicated that LBH staff who were involved in Trevor's care were aware of his risk for hyponatraemia, and were vigilant in monitoring his water intake. They implemented his treatment plan in a capable manner.

73. The conclusion I reach is that the treatment provided to Trevor for his complex mental health conditions was adequate.

74. However this assessment is made against the background of what is available for mentally unwell prisoners within a NSW correctional setting. The broader question, which I will now consider, is whether a custodial environment is capable of providing a patient like Trevor with the kind of mental health care that is needed.

Providing psychiatric care within a correctional setting

75. At the inquest the court heard evidence from Dr Sullivan, Dr Reznik and Dr Spencer about the extent to which Trevor's complex mental health needs could adequately be met within a custodial environment. In addition, at the request of the assisting team Dr Ellis provided a statement on this question after the close of oral evidence.

76. All four specialists have extensive experience in the provision of psychiatric services within a prison setting. For reasons which are set out below, they were unanimously of the view that for persons with serious mental health issues, correctional facilities are *not* able to provide the level of therapeutic care which these patients need.

77. In their evidence the specialists described the key differences between the model of psychiatric care offered in a prison hospital on the one hand, and a secure mental health facility on the other.

78. Dr Ellis described the LBH's Mental Health Unit as a hybrid unit. He explained that these:

    ' … tend to primarily apply a prison model, with security based on regulation and rational consequences …'

79. Dr Ellis stated that such models are historically ineffective in treating mentally ill prisoners.

80. In contrast, the Forensic Hospital is a secure mental health facility which is managed and staffed by the JH Network. Almost all its patients have been found not criminally responsible for their acts due to their mental illnesses, or are currently unfit to stand trial due to mental illness. It has no Corrective Services staff, but seeks to maintain a secure environment through the relations that its staff members develop with their patients.

81. Furthermore the Forensic Hospital administers what is known as a health-based model of care, focused upon development of a therapeutic relationship with the patient. Dr Spencer described this environment as one which:

    ' … fosters recovery that is not going to retraumatize, that enables an individual patient centred approach … '

82. She noted that by contrast, there is limited capacity within a prison to offer customised treatment to patients. An additional advantage of a non prison hospital is that it is operated and staffed by specialists trained in helping people who suffer mental illness and trauma. It also offers access to other professionals who can aid recovery, such as psychologists and occupational therapists.

83. Dr Reznik and Dr Sullivan acknowledged that as a prison hospital, the LBH offered the advantage of restricting Trevor's access to water. Nevertheless they were agreed that it was *not* conducive to developing a therapeutic relationship with patients. Dr Reznik explained that authoritarian systems do not provide a helpful context for developing a therapeutic relationship. He noted that while some correctional officers were sympathetic by nature, providing an empathic environment was not perceived as their role and did not form part of their training.

84. Dr Sullivan concurred that a prison environment does not foster psychiatric recovery. He commented that:

    '..being in prison gives people a prison mentality so it's a them and us mentality. There's often a degree of hostility or of an unwillingness to share information …In hospital however, with the absence of correctional staff, with the absence of security staff, it's more straightforward to be able to engage in a ... health-related discussion'.

85. It was Dr Sullivan's strong belief '*… that mental health disorders should be treated in mental health settings'.* He agreed that notwithstanding the resources that would be required, the optimal management of Trevor's condition would have been within a hospital setting.

86. Dr Ellis agreed. Forensic hospitals were, he said, '*essential components of a modern forensic mental health service'.* By contrast, a correctional model of care was not considered '*best or evidence based practice'* for mentally ill patients. He commented that in addition:

> *'Some interventions in prisons may exacerbate experience of trauma and cultural injury (particularly toward colonized cultures'.*

87. Dr Ellis opined that there would have been advantages for Trevor to have been treated for his condition of psychogenic polydipsia in the Forensic Hospital. He explained that in most cases, psychogenic polydipsia is caused by delusions or psychic distress. The most effective medication for this condition is clozapine, but it requires close physical monitoring of the patient, a difficult task within a prison environment. Dr Ellis noted this further impediment:

> '*Providing encouragement and diversion from water drinking is also more difficult to achieve when staff have less face to face contact with the patient, common in prison settings … where time in cell is lengthy'.*

88. At the close of the evidence, the assisting team, the legal representatives for the interested parties, and myself visited both the Forensic Hospital, and the LBH and in particular Trevor's former cell.

89. It was apparent that the physical environment of the two facilities is very different. The visit to LBH's G Ward confirmed the restrictive nature of its environment. Patients were housed in locked cells, and the hatch in Trevor's former cell door proved to be a rectangular space of about 60cm width and 15cm height. There can be little doubt that this arrangement would not have assisted Dr Reznik's aim of developing a therapeutic relationship with Trevor.

90. I accept the unanimous evidence of the specialist witnesses that notwithstanding the challenges of managing Trevor's psychogenic polydipsia, he needed to be treated within a hospital setting rather than a correctional one.

91. I accept the submissions of Counsel Assisting, and those on behalf of Trevor's family, that his complex mental health needs could not be adequately met within LBH. Submissions made on behalf of the JH Network and the Commissioner of Corrective Services NSW did not take issue with this.

The shortfall in resources for secure forensic hospital beds

92. The expert evidence was unanimous on this further point: that the model of mental health care provided within NSW prisons is not best practice for seriously ill prisoners, and leaves many of them without the care they need.

93. Despite the evidence that the Forensic Hospital would have been a more suitable psychiatric hospital for Trevor, it is almost certain that he could not have been admitted there.

94. The reason for this is the Forensic Hospital's limited bed capacity. Trevor would have joined what Dr Ellis described as *'a growing waitlist of adult male patients who remain inappropriately housed in custody'*. These patients include those who have been found not criminally responsible for serious offences due to mental illness, patients found unfit to be tried due to their mental illness or cognitive disability, and patients like Trevor who are serving a sentence of imprisonment but are involuntarily detained on mental health grounds.

95. Dr Ellis stated that the JH Network is now committed to ending the placement within prison hospitals of involuntary patients. Pursuant to this commitment, a new five bed unit is under construction at the Forensic Hospital. It is intended to enable involuntary patients within NSW prisons to be placed within the Forensic Hospital instead.

96. This is welcome news and will provide some assistance in meeting this important goal. But clearly of itself it will not be capable of providing enough secure mental health beds to meet the current need.

97. In his statement Dr Ellis outlined the further steps which the JH Network is taking to end involuntary treatment in custody. These include an Action Plan which proposes:

    - more medium secure forensic mental health beds to be developed in hospitals in the community
    - an increase in the rate of mental health diversion in the Local Court (noting the corresponding need for more community mental health services to accommodate the increase).

98. It is concerning that due to a significant shortfall in resources, prisoners with severe and chronic mental illness are not receiving the health care they need. In a number of recent inquests the NSW Coroners Court has received and accepted expert psychiatric evidence that the existing model of custodial care does not meet the needs of such prisoners. These include *Inquest into the death of F (*findings given 11 June 2021); *Inquest into the death of MH (*findings given 14 July 2021); and *Inquest into the death of Gavin Ellis (*findings given 2 September 2022).

99. In my view, the evidence at the inquest into Trevor's death amply supports the need for a recommendation which was proposed in the closing submissions of Counsel Assisting. This is as follows:

    That the Minister of Health NSW have regard to these findings, and the statement of Associate Professor Ellis (attached), in considering allocation of funding to ensure that prisoners who require a secure mental health bed are treated in a forensic hospital, rather than in prison cells.

100. The submissions on behalf of the Commissioner, Corrective Services supported this recommendation. No objection was raised to it in submissions on behalf of the JH Network.

101. The submissions on behalf of Tyson Samuel also supported this recommendation. I endorse Mr Rees' observation, that given the disproportionate incarceration rates of First Nations people, the shortfall in secure mental health beds:

> *' … is likely to further impact these already disadvantaged members of the community'.*

The family's proposed recommendation for continuing mental health training

102. In submissions on behalf of Tyson Samuel, a further recommendation was proposed that there be continuing mental health training for correctional officers working in LBH specifically, and in all correctional centres generally.

103. In response, the Commissioner submitted that this recommendation was not necessary as all correctional officers receive mental health training when they commence their employment. I accept this is the case.

104. Nevertheless it must be acknowledged, as did Mr Jason Hodge, Governor of Long Bay Correctional Centre in his supplementary statement dated 22 March 2022, that LBH's Mental Health Unit is a '*unique working environment'* for correctional officers. It was presumably for this reason that Governor Hodge stated there would be benefit for correctional officers working in its Mental Health Unit to receive refresher courses in relevant topics. He referenced certain face to face courses offered by the Brush Farm Corrective Services Academy, which include Mental Health Awareness, Trauma-Informed Practice, and Aboriginal Cultural Awareness.

105. Governor Hodge stated that while versions of these courses are provided to trainee correctional officers, he would consider providing ongoing training to correctional officers working in LBH's Mental Health Unit '*over the next year'*.

106. This would be a very welcome step. While I accept that some correctional officers working in LBH display empathy and understanding, it cannot be denied that the Mental Health Unit is quite distinct from the general areas of a prison, and that its cohort of mentally unwell inmates must pose distinct challenges for correctional officers. It would be to the benefit of both staff and inmates, if correctional officers working there were to receive refresher courses designed to increase both their awareness and their practical skills when interacting with its patients.

107. I therefore make the following recommendation:

> *That the Commissioner, Corrective Services NSW consider implementing appropriate and continuing mental health training for correctional officers working in Long Bay Hospital.*

108. I accept the submission on behalf of the Commissioner, that recommending refresher mental health training for *all* correctional officers is outside the scope of the issues identified in this inquest.

Culturally specific support for First Nations inmates

109. At the inquest, Tyson expressed the sadness that he and his family felt knowing that their brother had spent long periods of his life alone in custody. This raised a question as to whether more could be done to provide the kind of support for First Nations inmates which better reflects their First Nations heritage.

110. This issue is a very significant one, given the gross overrepresentation of First Nations people in custody. It is also an issue with which this inquest cannot hope to deal in any comprehensive manner.

111. However the evidence touched upon an issue which recurs in inquests of this nature, and that is the need to recruit and retain a higher proportion of health professionals with First Nations heritage.

112. It was acknowledged in the submissions of Counsel Assisting, and those on behalf of the JH Network, that this objective is not easily met. While NSW Health has adopted employment targets for First Nations staff, Dr Spencer spoke of the difficulty filling these positions in custodial environments which are, as she said, confronting workplaces for many qualified First Nations health workers. Illustrating this difficulty, the JH Network's submissions noted that although funding existed for seven full time Aboriginal Health Worker positions within the JH Network, only two were presently filled.

113. A further issue touched upon was the training which correctional officers and JH Network staff receive, to assist them in their care of First Nations patients. Submissions on behalf of Trevor's family called for '*relevant and continuing culturally safe training on culture and communication'.* This proposal is consistent with one of the many recommendations of the Royal Commission into Aboriginal Deaths in Custody, namely that custodial health practices:

> *' … demonstrate cultural awareness and be implemented in consultation with Aboriginal Health Services .. and the broader community'*.

114. In response to the family's proposal, the JH Network has submitted that mandatory cultural awareness training is presently being implemented throughout NSW Health, with the aim of delivering improved health services to First Nations people. The training program is delivered with an Aboriginal owned organization and is co-facilitated by the JH Network's Aboriginal Strategy and Culture Unit.

115. So far as Corrective Services NSW is concerned, the Commissioner relied upon submissions referred to in paragraph 100 above. These are to the effect that all correctional officers are required to undertake an 'Aboriginal Cultural Awareness' course when they commence employment.

116. However it is reasonable to assume that for some correctional officers, their primary training took place many years ago. It does not appear that the Commissioner mandates refresher courses in this area for his staff.

117. I have mentioned that in his supplementary statement, Governor Jason Hodge stated that he was considering implementing ongoing face to face training for officers working within LBH's Mental Health Unit. This, he said, might include training in Aboriginal cultural awareness and communication skills. I respectfully urge Governor Hodge to give serious consideration to implementing this proposal.

118. Finally, it was suggested in the submissions of Counsel Assisting that a policy could be developed within Corrective Services NSW, whereby management plans for First Nations persons in mental health facilities include some form of interpersonal support that reflects their First Nations heritage.

119. In response, the submissions on behalf of the Commissioner provided information about existing case management policies within correctional centres. These, it was submitted, include procedures to enable First Nations inmates to engage with community Elders and mentors. In addition, a Regional Aboriginal Project Officer and an Aboriginal Services and Programs Officer are attached to Long Bay Correctional Centre, both of whom visited Trevor while he was in custody there.

120. In the inquest the court did not hear evidence about the above case management policies. This is not a criticism of those representing the Commissioner, as these policies were not identified as a subject for examination at the inquest. In the absence of such evidence however, I do not consider that I am in a position to judge the degree to which they are able to meet the culturally specific support needs of First Nations inmates at LBH. I therefore make no recommendation in this area.

Conclusion

121. In closing, and on behalf of the assisting team, I offer my sincere and respectful sympathy to Trevor's family.

122. I acknowledge the excellent assistance I have received from those who assisted me, Dr Peggy Dwyer and the NSW Crown Solicitor. I also acknowledge the assistance of the other legal representatives appearing in the inquest. My thanks also to the Officer in Charge Senior Constable Elizabeth Tolland for her investigation and preparation of this matter for inquest.

Findings required by s81(1)

123. As a result of considering the documentary evidence and the oral evidence heard at the inquest, I am able to make the following findings in relation to Trevor Samuel's death.

Findings:	**Identity** The person who died is Trevor Samuel. **Date of death**: Trevor Samuel died on 2 March 2021. **Place of death**: Trevor Samuel died at Long Bay Hospital, Malabar NSW. **Cause of death:** Trevor Samuel died as a result of hyponatraemia due to excessive consumption of water, against a background of psychogenic polydipsia and treatment resistant schizophrenia. **Manner of death:** Trevor Samuel died of natural causes, at a time when he was an involuntary patient at Long Bay Correctional Centre Hospital.

Recommendation 1

To the Minister of Health NSW:

That the Minister of Health NSW have regard to these findings, and the statement of Associate Professor Ellis (attached), in considering allocation of funding to ensure that prisoners who require a secure mental health bed are treated in a forensic hospital, rather than in prison cells.

Recommendation 2

To the Commissioner of Corrective Services NSW*:*

That the Commissioner consider implementing appropriate and continuing mental health training for correctional officers working in Long Bay Hospital.

I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date 21 September 2022