CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of William Epere
Hearing dates	7-8 June 2022; 2 & 24 November 2022,
Date of findings:	24 November 2022
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Erin Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, 911 tool, corrective officer training in response to hanging,
File number:	2019/10495
Representation:	Ms Kathleen Zielinski, Counsel Assisting, instructed by Ms Bronwyn Lorenc, Crown Solicitors Office Mr Peerce McManus, Legal Aid NSW, for the family of Billy Epere Ms Georgia Lewer instructed by Ms Janet de Castro Lopo, Department of Communities and Justice Legal, for the Commissioner of Corrective Services Mr Darien Nagle instructed by Ms Christina Hatzigeorgiou, McNally Jones Staff Lawyers for the Senior Correctives Officer

Findings:

Identity

The person who died was William Epere

Date of death

He died on 10 January 2019.

Place of death

Dawn de Loas Correctional Centre, Silverwater NSW 2128

Cause

Hanging

Manner

Intentionally self-inflicted

Recommendations

a. That Corrective Services NSW give consideration to the provisions of ongoing specific practical training on hanging response, and audit individual participation rates annually to ensure attendance.

b. That Dawn De Loas Correctional Centre give consideration to ensuring compliance with the requirement to carry the 911 tool in accordance with Policy 5.3 Musters, Let-go and Lock in, through specific targeted education and random compliance checks.

Non-publication Orders:

A non-publication order was made pursuant to section 74(1)(b) of the Coroners Act 2009 in relation to specified documents in the coronial brief of evidence

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Introduction

1. Mr William Epere was just 43 years of age when he died at the Dawn De Loas Correctional Centre at the Silverwater Correctional Complex on 10 January 2019. The Inquest is mandatory, pursuant to sections 23(a) and 27(1)(b) of the *Coroners Act* 2009 (NSW) (the Act). It is important to have an Inquest to ensure that the State, which is responsible for those who are on remand or who have been sentenced, are being afforded proper care whilst their liberty is not their own.

2. Mr Epere was known as Billy, and I as was done in the Inquest, I will refer to him as such.

3. Billy had only been received into Dawn De Loas Correctional Centre on 27 December 2018, having been incarcerated on 14 December 2018, bail refused. He was sadly located hanging in his cell.

4. The Inquest is looking at the care and treatment of Billy by those responding to this medical emergency. The Inquest is considering whether the first responding corrective services officer acted promptly and appropriately when he found Billy hanging in his cell and whether his actions were compliant with Corrective Services NSW (CSNSW) policies. This includes whether or not he was issued with and carried a 911 tool, (an emergency tool that allows for a quick detachment of any hanging device), when he located Billy in his cell. Also, whether Billy received the correct immediate medical response in the circumstances.

5. Billy had blocked the viewing window to his cell. A further issue relates to the policy and procedures in relation to this practice. Finally, Billy was able to secure a sheet around a grille in his cell. The Inquest considered whether this could have been prevented.

6. Although this Inquest focuses on the time leading up to death, including interactions with police and struggles with mental health, it needs to be acknowledged that Billy was a much loved father, partner and brother. He was a person who clearly loved his family and had enjoyed good relationships prior to his more recent struggles with mental health. He is greatly missed by those that knew him, that was evident from the material in this Inquest and his the fact his family has an ongoing commitment to see change and improvement as a result of their sudden loss.

Reflection on Billy's life

7. Billy was born in New Zealand on 23 October 1975 as the second youngest of five children. The family moved to Australia in 1980 and lived in Blacktown, Western Sydney. He completed schooling to year 9 and then began work as a bricklayer. During these years, he was a hard worker, and very good at his job. He started his own bricklaying business when he was only 21 years old. Despite being initially successful, the business struggled. Billy could not maintain it and began working for other companies, but would regularly have falling outs with other staff members, ending in loss of jobs.

8. Following this, Billy had extended periods of unemployment. These began as just weeks without work, but later increased to months.

9. In 1994, Billy met his partner and they started a relationship. They moved in together in 1998 to a house in Schofields. Billy and his partner married in March 1999 and lived at the Schofields address for two or three years. They then moved in with his wife's parents in Baulkham Hills for a year while they built their house in Rouse Hill. They lived in that house until 2017 when they lost the house to the bank because they couldn't afford the mortgage repayments anymore. Billy and his wife separated after the loss of their home. His wife moved in with her parents and Billy moved in with his father in Parklea for a short time. Each of the children remained with their mother, except for the eldest son, who moved in with his girlfriend. Billy then moved to a rental

house in Kellyville Ridge for a short time but could not afford the rent. He then moved to a boarding house in Cherrybrook for a short time before moving into his sister's house in Schofields.

10. Billy and his wife had five children. The family were very close and had a great love for each other. Billy's mental health and financial difficulties made it very difficult for the family to function with him as they wanted. The aim of the family was to ensure that he received help, and improved his mental health, but sadly he would ultimately lose that battle.

Billy's Mental health history

11. Billy didn't necessarily show much emotion but was generally a happy person when he was well. In the context of his financial difficulties and relationship breakdown, his mental health started to decline. He attended a doctor in late December 2017 and was prescribed antidepressants. From this point up until his death, he was regularly prescribed medication to assist with his mental health.

12. Billy's sister recalls visiting him at the Kellyville house in April 2018 and found him sitting in the dark crying. He told her he 'didn't want to be here anymore' and that he wanted to kill himself. She took him to the doctor in Rouse Hill. It was shortly after this appointment that he moved in with his sister, who was a great support to him.

13. His sister recalls a distinct sadness about him. She spoke to him about his feelings and he was open about his feelings with her. He was constantly trying obtain mental health assistance. His poor mental health resulted in a decision that he could only talk to the children on the phone. He of course missed them greatly, and wanted to be well enough to see them and this was an ongoing frustration he expressed to his sister.

14. In May 2018, his sister received a phone call from one of their brothers, who told her that Billy was located in the driveway in the car trying to gas himself. Billy was then taken to Blacktown Hospital and admitted to Bungaribee House for assistance with his mental health. His sister visited him in hospital and three days later he was discharged.

15. Following his discharge from Bungaribee House, he seemed positive about things and was hopeful that things would change. He then went back to work and was trying to better things for himself and be more positive, with the aim of being able to be a father to his children.

16. Employment, however, was infrequent and he often was unable to pay his bills. Despite this, he would still go to the gym or go swimming after work to help clear his mind, which made him feel better.

17. His sister noticed a decline in his mental health and his behaviour over time. At times he would go to his children's school and wait across the road to see them. When he saw them, he would call out to them and wave.

18. In June 2018, Billy sold the family home and told his sister that he was going to give his wife 80% of the money after the loan was paid out.

19. In September 2018, his wife went to Court with Billy as a support person for a hearing with the Australian Taxation Office. He owed them $90 000. He set up a payment plan and agreed to pay back the money he owed.

Medical history of Billy

20. Prior to entering custody, Billy's physical health was unremarkable. It appears that in 2018 prior to being remanded in custody, he frequently attended at various medical centres as he was worried about various issues relating to his digestive system, such as reflux, bowel problems, gastritis and bloating in his stomach, but he had no significant physical health issues.

21. The first record of Billy speaking to a medical professional about his mental health was on 31 December 2017 when he attended Stanhope Medical Centre for a consultation. He explained to the treating doctor that he had recently lost the family home and had separated from the family. He did not report having any suicidal thoughts or ideation and he was diagnosed with moderate/acute depression, anxiety and hypertension. He was prescribed Lexapro 10mg and Coversyl 5mg. He declined a psychological referral.

22. He next attended on 3 January 2018 for a follow up appointment. He stated that he was feeling better, calmer and was a bit drowsy which was a side effect of the antidepressant and he stated he would get used to it.

23. In January 2018, he attended the GP for reasons unrelated to his mental health. The GP noted that 'his mood was much better'.

24. On 4 May 2018, he attended a medical centre due to concerns with his depression and anxiety. The notes state that he had extreme anxiety about his liver and thought that he may need a transplant.

25. The first hospital admission for mental health was on 18 May 2018. He was discharged on 21 May 2018. On this occasion, Billy was bought in by an ambulance having been 'scheduled' under the Mental Health Act due to suicidal thoughts in the context of multiple psycho-social stressors. It was noted that he had been dealing with a family breakdown and the loss of the family home and due to all of these, had been thinking about suicide a lot. The notes further state that when he went to work he felt like he could not tolerate any more and was thinking to end his life. His discharge plan included the need for him to attend a review with his GP in a couple of days, a recommendation that he continue taking Mirtazapine and to contact a mental health service if needed.

26. On 26 May 2018 he attended a medical centre for his mental health. He was prescribed Avanza Soltab 15mg.

27. On 5 June 2018, he attended a medical centre for his mental health. The consultation notes state that he was asking to see a counsellor in Kellyville. He denied any suicidal thoughts. A mental health plan was compiled, and a Kessler 10 assessment was done. He was prescribed Avanza 45mg tablet (1 per day) and told to avoid alcohol.

28. The second hospital admission was on 28 June 2018. On this occasion he was voluntarily admitted for a mental health assessment. Ambulance records note that police were on scene when they arrived at his house and he told them that he had thought of stabbing himself. On this occasion he had told Ambulance officers that he didn't have any actual intention to hurt himself and that his medications were helping him. He did not meet the criteria to be scheduled under the Mental Health Act and was released into police custody.

29. On 8 August 2018, Billy attended a medical centre for a long consultation. He told the doctor that he was worrying all the time, not seeing a psychologist, although had seen one once but didn't like her, that he needed 'the plans' again, he had denied thoughts of suicide or self-harm, was asking for an Avanza prescription and that he seemed non-compliant with everything. The note states that he was advised to see a psychologist first before being prescribed Avanza and that he looked anxious.

30. On 20 September 2018, he attended a medical centre and discussed his mental health. He told the GP that he had some counselling and was prescribed Avanza 45mg.

31. On 2 October 2018, Billy attended Rouse Hill Medical Centre for a radiology appointment and a mental health consult. He was prescribed Plim tablets 200 mg as a mood stabiliser.

32. On 12 December 2018, he attended again and requested a mental health care plan. He was given a mental health care plan and an Allied health plan referral.

Billy's interactions with NSW police

33. Billy had limited interactions with NSW Police until the breakdown of his relationship with his wife in late December 2017.

34. On 19 December 2017, police applied for a non-urgent ADVO protecting his wife from Billy as a result of Billy attending her parents' home and having an argument with her about contact with the children.

35. The next instance that the police were called to attend was at about 6:30am on 1 January 2018, where Billy attended her parents' house and began to call out for her. His wife told police that Billy continually turned up at her parents' house and for various valid reasons and that she did not want him to keep doing this. Billy was taken into police custody at Castle Hill Police station and served with an apprehended domestic violence order.

36. On 16 January 2018, this provisional order was finalised for a period of 12 months. Billy was in court at the time the order was made.

37. On 28 January 2018, his wife received a number of text messages from Billy stating that he was 'coming around.' At 7:50pm, Billy arrived at her parents' house. Billy's eldest son met him at the front of the house and they had an argument about his presence at the house. The Police were then called. No charge for breach of the ADVO was laid, and an application to include a condition that he not come within 100m of the house was applied for.

38. On 13 February 2018, conditions were added to provide that Billy not go within 100m of any place where his wife lived or worked and not to go within 100m of his wife's residence.

39. At 4:00am on 15 May 2018 his wife woke up to her dog barking and could hear Billy banging on the garage door. She saw that she had 20 voicemail messages from Billy and she called the police. When the police arrived, they saw him sitting on a chair within 100 metres of her parents' home. Billy was then arrested, taken to Castle Hill Police station and charged with an offence of Contravene ADVO. He was taken into Police custody to appear at Court that day, and entered a plea of guilty to that offence. On 29 June 2018 he was fined $750.

40. On 3 June 2018, Billy attended his wife's parents' home and called out to his children. After being asked to leave, he did so a short time later. The Police were called and Billy was charged for breaching his ADVO. He entered a plea of guilty on 6 June 2018, was fined $500 and placed on a section 9 bond for 12 months.

41. On 5 June 2018, Billy called his wife 9 times from his mobile phone on a private number. Each time he left a voice mail. This was reported this to the Police and Billy was arrested at his home address at about 8:30pm. He was taken to Castle Hill Police station and interviewed about the phone calls. He made admissions and told the Police that he was disgusted in himself. In his wife's interview with the Police, she stated that Billy may be suffering from an undiagnosed mental health condition. This was raised in the interview with Billy and he agreed with this. Billy was charged with breaching the ADVO and breaching his bail conditions and fined $200 at Parramatta Local Court on 6 June 2018.

42. On 28 June 2018, his wife again woke up to a number of voice messages in her phone from Billy. These messages were left between 3:11am and 7:15am. Sometime after making these calls, Billy called triple 0 and said he was not

feeling well. When she took the children to school that day she saw him waiting in the carpark. He approached her and they had a conversation. Later in the day, police attended Billy's home in relation to the triple 0 call. Billy told the police that he had just finished calling his wife and that he felt like stabbing himself in the early hours of the morning. He was then voluntarily taken to Blacktown Hospital for a mental health assessment and released a few hours later. He was charged with breaching the ADVO.

43. On 15 September 2018, his wife received at least 9 missed calls and a number of voicemail messages. The voicemail messages were from Billy. At 2:50pm she received a voicemail which stated "I'm out the front. Send (the children) out or do I have to come up?" As a result of this, she sent the children outside to see Billy.

44. At about 8:30am on16 September 2018, his wife was at home and heard a male voice she immediately recognised as Billy's, call out to the children. Her father went outside and spoke to Billy who then left. Following this, She then received numerous voicemails on her mobile phone until her mailbox was full. Telecommunications records show that Billy contacted her at least 15 times. Billy was charged with breach of ADVO on 17 September 2018, and granted conditional bail the following day. The conditions of his bail included a condition that he comply with the Apprehended Domestic Violence Order and that he not go near or try to contact his wife.

45. On 23 October 2018, his wife received a number of abusive voicemail messages from Billy after she unblocked his phone number so that her children could call Billy for his birthday. Billy then attended her home at 11am and demanded to speak with her. The Police were called and Billy was arrested that day, charged with breaching his ADVO and bail refused at Parramatta Local Court and remanded into custody.

46. On 29 November 2018, Billy was sentenced to a 12 month intensive corrections order for three separate instances of breach ADVO. He was released from custody on this date.

47. On 3, 4, 6, 9 and 11 December 2018, Billy either attended his children's school or left a voicemail on his wife's mobile telephone. Each of these instances were a breach of the enforceable apprehended violence order. On 13 December 2018, Billy was bail refused by Police overnight and was formally bail refused at Blacktown Local Court the following day.

48. I repeat these facts for this reason. It was the case that over this time Billy's mental health was deteriorating greatly. He was not able to manage it, was not able to be, while in that state, with his family. The above demonstrates his inability to regulate his behaviour in compliance with the ADVO. His inability to regulate himself resulted in an escalation in breaches of the ADVO in a very concerning manner. The ADVO is never a piece of paper, it is an order put in place by Court in this case to ensure personal protection and safety. Police gave him opportunities to correct the behaviour and yet it continued, to the point that he found himself deprived of his liberty on the basis that he could not comply with the Court Order. It is important to reflect that this is not the person in need of protection's order, it is in fact a Court Order, and it is for the Court to determine what action is required to resolve the continued breach, which it did.

Billy's mental health while in custody

49. On 14 December 2018, Billy was remanded at Amber Laurel Correctional Centre. On 16 December 2018, he was transferred to the Metro Remand and Reception Centre (MRRC).

50. On 27 December 2018, Billy was transferred to Dawn de Loas Correctional Centre. A case note states that he was taken to the clinic with no thoughts of

self-harm but had a feeling that inmates wanted to fight him. As a result of this, he was placed in a segregation cell for the evening.

51. A case note from 28 December 2018 states

> '*Inmate not yet seen, triage completed based on available information. Inmate placed on PSYCH2:Sub-Acute Mental Health Impairments waitlist, will be seen in order of priority*.'

52. A further case note from this date notes that
'*inmate maintained eye contact and was polite but he appeared confused/unable to decide about his answers. He denied any thoughts of self-harm or thoughts of any violence against others. When enquired about any existing mental health issues he said that he had been waiting to see a mental health practitioner for some time. Author contacted DDL Clinic and Visiting Mental Health agreed to see the inmate same day. Nil concerns expressed by inmate if he was made normal placement. After discussions with MOS, inmate was let out to normal routine in H-block.'*

53. A case note dated 29 December 2018 states

> '*spoke with inmate EPERE today to see how he is going he stated that he is OK and feeling good, Inmate let go to normal discipline*.'

54. It appears that Billy saw a psychologist in custody on the 31st of December 2018. A case note from that session states that

> '*Billy reported that currently he was experiencing significant difficulties with sleep…….*

Billy also stated that he doesn't care anymore. This was explored and he stated he just wanted to be left alone and do me. He stated that he was still waiting to see mental health regarding medication. He denied any current suicidal and/or self-harm ideations, intentions and/or plans. He was future oriented to his release. He also agreed that should his mental state deteriorate; he would seek additional support.'

55. He was assessed as a low risk of self-harm /suicide at the end of the session.

The circumstances of Billy's death

56. At 3:09pm on 9 January 2019, Billy was locked into his cell in H block by Correctional Services Officers. Throughout the course of the next few hours, Billy can be seen on CCTV footage through the window of his cell.

57. In the early hours of 10 January 2019, the CCTV shows the light in Billy's cell was turned on and off and movement can be seen through the window of the cell. At 12:31am, a light was turned on in Billy's cell. At 12:35, the window of the cell appeared to be covered in a white sheet.

58. At 6:52am, A Senior Correctives Officer was performing a count of the inmates and noticed that a sheet was obstructing the door of Billy's cell. The senior Correctional Officer immediately unlocked the cell door and the first thing he saw was Billy's feet suspended in the air. He moved the sheet and saw Billy had tied a sheet around his neck and was hanging from the air vent above the door. He saw that his skin had darkened in colour and that his face was pressed against the door. He saw that he wasn't wearing a shirt and that his green track pants were pulled up just below his knees.

59. What occurred next was not in accordance with policy. Four Correctional Officers were involved in the initial response. The first I will refer to as the

Senior Correctional Officer. He was a function manager, which meant that he would overlook the daily routine of the wing, he would also manage up to 6 other officers. He was the most senior officer in the pod on that day.

60. The first and second Correctional Officers present at the time were very much the subject to the direction by the senior correctional officer.

61. The Senior Correctional Officer was very frank and honest in the giving of his evidence. He described arriving at the cell door, opening the door, seeing Billy suspended in the air with a bedsheet around his neck tied onto the grille above the door. His face was pressed against the door flattening his nose out and there was discoloration in his feet. He quickly formed the opinion that Billy was deceased and could not be revived, He called his name, with no answer and touched him, and then he closed the door.

62. He indicated that he could not cut Billy down, as per protocol, because he did not have his 911 tool with him. He spoke with two junior Correctional Officers who he said also didn't have the tool, and so the Senior Correctional Officer called for a medical response and an immediate critical response and then waited outside the door. He called on his radio saying "can I have a response down H block, both medical and custodial."

63. He expected that would get immediate action. At that point he asked both officers whether they had a 911 tool, and found they didn't. He asked the first Correctional Officer to do the head check to make sure the other inmates were accounted for and sent Second Correctional officer to get a 911 tool. He explained that the reason he closed the door on Billy's cell was to not further traumatise other inmates. He gave evidence that a few of the inmates were becoming distressed.

64. It was his evidence that the second Correctional Officer returned with the tool. Consistent with this, in the CCTV footage as that officer reaches him, he reached out his hand for the tool. By that time another experienced officer, the Correctional Officer from I block had arrived. They entered the cell, the Senior

Correctional Officer handed him the newly located tool. The Senior Correctional Officer lifted Billy, taking his weight. The Correctional Officer from I block then cut Billy down, while the Senior Corrective Officer lowered him to the ground. The Correctional Officer from I block commenced CPR immediately.

65. The first Correctional Officer was relatively new in the job, having trained only 8 months prior. He tried to assist the Inquest however his memory was not strong in relation to the important few minutes. He described himself as being in a state of panic. He was quite shocked by what he saw when he looked in the cell. He couldn't recall if he had the 911 tool, but his usual practice was to carry one. He indicated that it was not usual practice for someone to check that he had it.

66. The second Correctional Officer didn't have a very thorough memory of the events. He said that he was directed to secure the other inmates. He said that he didn't know what had happened initially. He said however, he knew it was a crime scene, and he wanted to make sure "no inmates come". That was somewhat inconsistent with not knowing a death had occurred. He said he was sent to lock the sweeper in, who was out at that time working. When he was observed in the footage, he was seen putting on gloves as he went away from the cell down the stairs. To explain this he said "normally something like incident happen so we just put the gloves on, yes". Again, this is more consistent with him being aware of the death and starting to take action. He didn't recall if he had the 911 tool that day. He said he would ordinarily carry the tool.

67. The Correctional Officer from I pod arrived as quickly as he could after hearing the call. He immediately said to open the door. He was well aware that he needed to act. He believed that he would have been carrying the tool, however, in his statement he said that he asked the second Correctional

Officer for the tool. This is in keeping with the account from the Senior Correctional Officer and the objective CCTV footage.

Concluding remarks on the evidence

68. I have watched the objective evidence, being the CCTV footage. That footage does not capture all of the events, but much of them, and is the preferred evidence. The Senior Correctional Officer gave a very different account in his statement, he thought he had immediately attended upon Billy, holding him up. In his oral evidence he agreed that he was mistaken about that fact. I do not find that he wilfully mislead the Inquest in his statement, rather his recollection was clearly affected by the event. The CCTV clearly shows the opening of the cell door by the Senior Correctional Officer and the closing of it very quickly. Minutes passed before the door was reopened. There is a sense of confusion from that point, and inaction in relation to helping Billy. It seems clear that no one had the requisite tool available to enable a quick cut down, and that is consistent with the Senior Correctional Officer's evidence, an officer does go searching for one. I am uncertain of where it was found but it was eventually handed to the Senior Correctional Officer and then to the Correctional Officer from I block who used the tool.

69. The first Correctional Officer was honest and forthright, he said that he was in a panic and I accept that this affected his recollection. I find that the second Correctional Officer had limited recollection of events, and some of his memory was inconsistent with the footage. The Correctional Officer from I block was impressive, he had some gaps in his memory which he acknowledged. He acted swiftly to resolve the situation for Billy, however he did say that much of his training came from previous employment. Overall in relation to the significant events I preferred the Senior Correctional Officer's account. He was acutely aware of the failure to have the tool, his focus was on gaining a means to assist Billy in his cell. The objective evidence supported the fact that no one had the tool, an officer was sent to get one and it was brought back and handed to the Senior Correctional Officer allowing Billy to be brought down.

70. The Senior Correctional Officer said that he did not receive training on the importance of carrying the 911 tool, except when he completed his initial training which was some 20 years prior. His account was that the manager of security would sometimes remind them to pick up the tool, and sometimes not. He said this “every time I spot someone without one I keep reminding them I’m going to an Inquest for this reason, so please put one on.” That evidence was supportive of the finding that the system is still not properly working to ensure the carrying of the 911 tool.

71. Officers said that they would benefit from training on self-harm incidents. The Senior Correctional Officer had not been trained using a scenario in 20 years. He had never been faced with a hanging. This matter highlights the need for regular training. He failed to take the steps that he could when faced with this terrible situation, and at least try to alleviate the pressure on Billy’s neck by trying to hold him up and requesting assistance if needed.

72. He was also so concerned about his own failure to pick up the 911 tool in breach of protocol that he didn’t even radio about the need for one. The policy provides that a 911 device should be available in the accommodation areas of such a facility. The evidence was silent on this issue.

73. There was a focus initially on the blocking of the window in the door by inmates. As was stated in evidence, it is a practice that is against policy, but it often done. It was raised in evidence that correctional facilities are often weighing up the individual needs and wishes of inmates and safety needs. It was said that issues of privacy can be important for wellbeing of inmates in such a complex environment. After hearing submissions from Counsel Assisting and all parties I do not, in this Inquest propose to make any recommendations on that issue.

74. There was also a focus on the grille and consideration of hanging points in the correctional facility. Billy did locate a point within his cell to attach the sheet. His family are concerned about the ability for a vulnerable person to find such

a point. The Inquest heard evidence that this is an ongoing issue in relation to keeping an inmate comfortable while trying to eliminate all such points. I agree with the family that this is a constant issue that should be addressed in each correctional facility, but on the facts of this matter I do not intend to make a formal recommendation on the matter, knowing the relevant bodies will have the opportunity through receiving the findings of this Inquest to consider this issue generally.

75. Finally the family did also raise concern about mental health treatment for Billy while in custody. This did not form part of the scope of the Inquest, but again I want to echo that Billy's death reflects poorly on mental health treatment generally in our community. He sought out help himself, but it seems wasn't able to obtain as much as he required, even while at liberty. Again Billy gives the community the chance to reflect on the greater need for resources and general understanding of psychological health generally.

76. The policies are clear. Custodial Operation Policy 13.2 outlines the Corrective Services NSW policies with respect to medical emergencies and Policy 13.1.3 deals with 'hanging or strangulation'. A number of aspects of these policies are of particular relevance to these proceedings. These include the following:

COPP 13.3

1 Initiating an urgent response

Where a correctional officer discovers an inmate who appears deceased, the officer must immediately call for an urgent response.

2.2 Safety precautions when entering cells

During correctional centre lock-in hours, an officer must not enter a cell without another officer being present. (Refer to COPP section 5.5 Cell security and alarm calls).

At all other times, an officer must ensure assistance is on the way before entering a cell. Before entering, officers must ensure the door bolt is secured so they cannot be locked in.

2.3 First aid and medical assistance

The discovery of an inmate who appears deceased must be treated as a medical emergency. For medical emergency response procedures refer to COPP section 13.2 Medical emergencies.

COPP 13.2

1.2 Providing first aid

Immediately following a call for urgent medical assistance, first aid must be provided to an inmate. If there is more than one officer present, one officer must commence first aid while the other calls for medical assistance. Officers must use the appropriate Personal Protective Equipment (PPE) and follow infection control guidelines. Refer to subsection 1.3 Hanging or strangulation of this policy for additional procedures where an inmate is found hanging or strangled.

1.3 Hanging or strangulation

When an inmate is covered hanging or strangled, immediate action must be taken to safely remove the ligature and place the inmate on the ground. When removing a ligature, it is important to leave the knot intact for forensic examination if possible.

CPR is unlikely to be effective if applied on mattresses or uneven surfaces. An inmate should always be moved to an area appropriate for CPR with adequate space for JH&FMHN personnel, paramedics and resuscitation equipment. Care must be taken to support the inmate's head and neck during movement.

77. Furthermore, policy 5.3 Musters, Let-go and Lock In at 4.1 makes compulsory that all custodial staff whose duties involve contact with inmates must be issued with and carry this tool (911) at all times for the duration of the shift. It also provides that additional 911 tools must be stored in places accessible to correctional offices in inmate accommodation areas.

78. There was a number of failings in relation to Billy. These failings however are not suggested to be ones that could have altered the course of the ultimate outcome for Billy. On all accounts Billy was deceased by the time he was found, and unable to be resuscitated. However, that might not have been the case.

79. The evidence overall paints a picture of some general poor practice in officers carrying the 911 tool. It also was also consistent with various officers indicating that they would definitely benefit from some scenario-based training, on a more regular basis. The two issues are closely aligned. To educate on what to do when faced with a hanging necessarily explains the necessity to always carry the 911 tool.

80. This is important for the wellbeing on inmates, and for the WHS of the officers and their ongoing wellbeing. There was no doubt that Billy's death, and the mishandling of his situation has taken a significant toll on the Senior Correctional Officer. From this event he has reflected, learned and is teaching others with this knowledge, but it was clear that although policies do exist that at Dawn De Loas Correctional Centre it would be of great assistance to have further training and also some mechanism to ensure that the 911 tool is always being carried in the event of an emergency. It was clear from the evidence that observations are still being made of others on duty who are not carrying the tool.

81. It appears that some officers at Dawn De Loas Correctional Centre may have developed complacency about the carrying of the 911 tool. The reaction of at least three of the officers was one more consistent with officers going into a

state of shock at finding Billy and highlights the need for regular training and education on the issue of hanging incidents. The officers were very troubled by what had occurred. They showed remorse where appropriate, and care for Billy's situation. The Senior Correctional Officer was of great assistance in the Inquest with his candour and honesty. He has changed his practice, educates other officers but also welcomed the opportunity for additional training in the area of responding to self-harm incidents.

82. It would seem that given the committed officers of Dawn De Loas Correctional Centre were asking for training and better compliance generally, that Dawn De Loas Correctional Centre would wish to see that all is done to ensure a much better response in the future. It is recognised that the officers are faced with a very difficult and challenging role. It therefore is imperative that in the face of crisis they feel well equipped to respond with certainty and confidence.

83. It is trite to say that responding to a self-harm incident in accordance with policy and protocol is critical. These policies are in place because there is often a chance to save a life if proper response is given. It is for medical officers to determine whether a person is deceased, and this is usually only done after CPR is commenced. The officers should never be more concerned about their own failure when calling for assistance.

84. It is hoped the proposed recommendations go some way to assisting those at Dawn De Loas Correctional Centre and NSW Correctives generally to make some improvement to better equip staff and potentially save a life.

Acknowledgements

2. Firstly to Billy's family. Their presence at the Inquest was greatly appreciated; the family statement brought out the love that Billy had for his family and the love they had for him in return. The family shared a story of a struggle with

mental health and a desire that he receive proper treatment which they felt he didn't ever receive.

3. Detective Senior Constable Peter Phillp attended Dawn De Loas. He then conducted a number of interviews and gathered evidence ultimately preparing a brief. I thank him for his commitment to the matter and thorough investigation.

4. To the representatives for each party thank you for ensuring that the Inquest was conducted in a useful manner and attempting to explore mechanisms for improvement.

5. To the Ms Zielinski and Ms Lorence. Much time and effort went into the preparation for hearing, the issues for consideration and calling of relevant witnesses. The submissions prepared were so helpful in the preparation of the factual material in this matter. I thank you for the care that you have afforded Billy.

Recommendations

a. That Corrective Services NSW give consideration to the provisions of ongoing specific practical training on hanging response, and audit individual participation rates annually to ensure attendance.

b. That Dawn De Loas Correctional Centre give consideration to ensuring compliance with the requirement to carry the 911 tool in accordance with Policy 5.3 Musters, Let-go and Lock in, through specific targeted education and random compliance checks.

Findings

The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was William Epere

Date of death

10 January 2019.

Place of death

Dawn de Loas Correctional Centre, Silverwater NSW 2128

Cause

Hanging

Manner

Intentionally self-inflicted

I extend my sincere condolences to the family of Billy.

I close this inquest.

Magistrate E Kennedy
Deputy State Coroner
24 November 2022