CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of DP
Hearing dates:	11 – 13 September 2023
Date of findings:	16 November 2023
Place of findings:	NSW Coroners Court Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; self-inflicted death; hanging in correctional centre; requests for medical treatment; sleep apnoea; obtaining CPAP machines in custody; adequacy of morning checks
File Number:	2021/94740

Representation:	Counsel assisting Mr Jake Harris instructed by Ms Catherine Moore of the NSW Coroner's Court Mr Ben Wilson for St Vincent's Correctional Health instructed by [redacted] Hall & Willcox Mr Tim Hackett for MTC Broadspectrum instructed by Mr Shaun Bailey of Ingenium Legal Ms Janet de Castro Lopo, Department of Communities and Justice Legal, for the Commissioner of Correctives Services NSW Mr Ben Bradley for Justice Health and Forensic Mental Health Network, instructed by Ms Kate Hinchcliffe of Makinson D'Apice Lawyers Mr Robert Reitano for Correctional Officer Mark Ward, instructed by Ms Emily Lucas of McNally Jones Lawyers
Non publication orders:	Non-publication orders made on 3 February 2023 and 11 September 2023 prohibit the publication of various persons' personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.
Findings:	**Identity** The person who died was DP **Date of death** He died on 4 or 5 April 2021 **Place of death** He died at Parklea Correctional Centre, NSW **Cause of death** He died from hanging

	Manner of death His death was intentionally self-inflicted.

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Introduction

1. This inquest concerns the death of DP. DP died between 4 and 5 April 2021 whilst on remand at Parklea Correctional Centre. He was 52 years of age.

2. DP was loved by family members, some of whom attended the inquest.

The role of the coroner and the scope of the inquest

3. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

4. DP was a prisoner with certain pre-existing health conditions at the time of his death. It was necessary to examine the way in which these issues were managed in custody to understand whether they had any relevance to his apparent decision to take his own life.

5. For part of his period in custody, DP was held at a privately operated prison. Parklea Correctional Centre (Parklea) is privately managed and operated by Management & Training Corporation (MTC) pursuant to the terms of a Management Deed with the Commissioner of Corrective Services (CSNSW). Medical care for inmates at that facility is provided by St Vincent's Hospital Sydney Limited (SVH) pursuant to an agreement with MTC. Prisoners housed in privately run prisons are entitled to the same level of care as those housed in facilities directly managed by the State of NSW.

6. It should be noted that when a person dies in custody in NSW, it is mandatory that an inquest is held.[3] The inquest must be conducted by a senior coroner.[4] When a person is detained the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice it is especially important that the care they are offered is of an appropriate standard.

The evidence

7. The court took evidence over three hearing days. The court also received extensive documentary material in eight volumes. This material included witness statements, medical records, policies and procedures, and the report of an independent expert psychiatrist, Dr Danny Sullivan. Dr Sullivan gave oral evidence before me. The court also heard from custodial officers and those involved in custodial management, DP's cell mate at the

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[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] Section 27 *Coroners Act* 2009 (NSW).
[4] Section 24 *Coroners Act* 2009 (NSW).

time of his death and medical staff involved in his care or in the management of relevant health services.

8. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

9. A list of issues was prepared before the proceedings commenced. [5] These issues guided the investigation and focused on procedures in place in the lead up to DP's death.

Background and brief chronology

10. DP was born in Sydney, to parents ▇▇▇ and ▇▇▇. They separated when he was young. He had two older sisters, ▇▇▇ and ▇▇▇. DP attended Drummoyne Boys High until Year 11. When he was 13, his father died. Following this, and in the context of leaving school and smoking cannabis, it appears that DP developed his first symptoms of depression.

11. After leaving school, DP worked in warehousing and construction and then had his own business as a painter/decorator. He undertook some study and later worked for the State Rail Authority.

12. He met his wife, ▇▇▇, and they married in 2000. They had two children together before eventually separating in March 2016. Divorce proceedings commenced later, and these were continuing at the time DP entered custody. At the time of his death, DP was involved with a new partner.

13. Unfortunately, DP had poor mental health which worsened sporadically throughout his adult life. He attended doctors and psychiatrists from about 2003. He was initially treated

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[5] Issues List

Whether procedures and policies in place, for responding to, allocating and actioning 'self-referrals' forms lodged by inmates requesting medical care are sufficient, and whether the process can be improved upon.

Whether additional medical care and supervision should have been provided given Mr DP known history of depression and multiple self-referrals to Justice Health/ St Vincent Correctional Health.

If the overnight and early morning checks and patrols conducted in Area 1 were sufficient, and what, if any, other welfare checks and mental health assessments should have been conducted on DP in the circumstances.

Whether the current procedure around the screening of inmate mail is sufficient to identify inmates who may be at risk of self-harm?

Whether the failure to provide DP with the requested medication and sleep apnoea machine contributed to his poor physical and mental health and consequent actions.

with medication for depression, but it was later believed that he might have bipolar disorder. He had some manic episodes, which may also have been related to drug use.

14. One psychiatrist, Dr Clayton Smith, assessed DP in 2012, and diagnosed him with bipolar disorder type II. However, he reviewed DP again in 2016, and noted that DP had been able to manage his mental health, primarily by remaining abstinent from illicit drugs. At that time he did not believe DP met the criteria for any mental disorder, although he had some personality vulnerabilities.

15. Dr Danny Sullivan, a consultant forensic psychiatrist conducted a *post mortem* expert review of the available medical records for this court. Dr Sullivan's opinion is that DP had a severe substance use disorder, and major depressive disorder, which was mild to moderate in severity. He told the court that DP appeared to have a propensity to experience mood disorder that was exacerbated or precipitated by drug use. Dr Sullivan stated that it was not clear that DP had a clinically significant mood disorder in the absence of drug use. Dr Sullivan stated that DP had personality vulnerabilities, which were likely to have been exacerbated by drug use. He told the court that it was clear that DP had depressive episodes and episodes of escalated mood, however he could not determine from the records whether these escalated moods would have met the criteria for hypomania.[6]

16. DP also had many serious physical health problems. As a young adult, he developed ankylosing spondylitis, a chronic inflammatory disease of the spine. He suffered ongoing pain and required repeated surgeries. He received weekly injections of Enbrel or etanercept medication to control his symptoms, and he received pain medication.

17. DP also suffered from sleep apnoea. In November 2018, his General Practitioner (GP), Dr Emma Wakeling, referred him for a sleep study. The study revealed that DP was suffering about 36 episodes of sleep apnoea per hour. He was reviewed by a respiratory and sleep physician, Dr Alistair Abbott, who confirmed DP had severe obstructive sleep apnoea, and recommended a trial of a CPAP machine (Continuous Positive Airway Pressure).

18. DP used the machine on a trial basis for the next three months. At the next review, in February 2019, Dr Abbott noted that DP was not using the machine consistently, and was somewhat intolerant of it, only using it on average for about four hours per night. It is also reported that DP had good symptomatic benefit when he used the machine correctly. After discussion it appears that DP was willing to continue with the CPAP, and Dr Abbott planned to see him again in one year.

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[6] T13/09/23 17.44-48

19. There is no record that DP attended any follow up in the community for this condition after February 2019.

20. In late 2019, DP was living in a rental accommodation at Burwood. He told a Community Corrections officer that he was using Ice at this time, and that he had lost his job and was living off savings.

21. In October 2019, DP was convicted of offences including possession of drugs, and was given a community corrections order. He started the MERIT program, and commenced drug rehabilitation. However, in late 2019 he faced further charges of assault, contravening an AVO and a stalking offence. He failed to report to Community Corrections, and a breach report was issued. It appears that this may have been a particularly difficult and chaotic period for DP.

22. On 27 May 2020, DP was arrested on a murder charge. DP maintained his innocence and the charge was outstanding at the time of his death. He was bail refused in relation to this matter and entered custody at Amber Laurel Correctional Centre.

23. While it is unnecessary for these coronial proceedings to outline this allegation, the details were widely reported and extremely serious. It is most likely that the impending proceedings and his possible long term incarceration impacted heavily on DP's state of mind in the period leading up to his death.

The first period at Parklea Correctional Centre, May to August 2020

24. On 28 May 2020, DP was transferred to Parklea Correctional Centre. He remained there for about three months, before being transferred to Shortland Correctional Centre.

25. Parklea was operated at the time of these events by a joint venture between MTC and Broadspectrum. Health services were provided by St Vincent's Correctional Health (SVCH). The role of Corrective Services NSW and Justice Health & Forensic Mental Health Network (JHFMHN) is limited to statutory monitoring.

26. At the time of his reception, DP was health screened. He reported his medical history, including the ankylosing spondylitis, arthritis, hypertension, and sleep apnoea. He later reported a nerve impingement. Due to these conditions, information was sought from his General Practitioner, and he was scheduled for a Chronic Disease Screen.

27. DP also reported a history of a mental health issues, dating from 2003. However, he said he was not currently on medication. He denied any thoughts of self-harm, or previous attempts at self-harm. He was recommended for a shared call.

28. Over the next few months, DP completed 19 requests for medical attention. He also submitted similar forms at Shortland Correctional Centre. He raised various concerns about

his need for treatment, including the weekly injection he needed and in relation to pain medication. At times he complained that he was not receiving the treatment he required.

29. Although DP had referred to his sleep apnoea at reception, it appears that at this time he did not mention, or it was not recorded that he had used a CPAP machine in the community. The first occasion it appears to have been specifically raised was in an email sent by his sister on 2 July 2020. The following day, DP attended the health clinic, and gave some details about his CPAP machine. It is recorded that he told staff it was a Phillips machine, that he used pressure setting 20, and that he used a nasal tube.

30. Staff sent a request for the sleep study DP had undertaken in 2018, and later for the report from Dr Abbott.

31. The court was informed that at this time, in 2020, neither JHFMHN nor St Vincent's Correctional Health had access to a supply of CPAP machines that could be issued to prisoners. This is an issue to which I will return.

32. During July and August 2020, enquiries were made about obtaining a new CPAP machine for DP, from CPAP Australia and from St Vincent's Hospital, and also about trying to obtain DP's machine from the community. However, DP told staff that he didn't know where it was. By the end of August 2020, attempts to obtain a new one had been unsuccessful. A GP at the gaol, Dr Tattersall, advised that DP should have weekly reviews to monitor his symptoms, and suggested exercise to reduce the effects.

The period at Shortland Correctional Centre, August 2020 to January 2021

33. On 29 August 2021, DP was transferred to Shortland Correctional Centre. He remained there for about five months, before returning to Parklea in January 2020.

34. DP again submitted patient self-referral forms about his health, five in total. He referred to his need for a CPAP machine as early as 30 August 2020.

35. He was placed on a General Practitioner waitlist, and reviewed by a GP, Dr Foley, on 8 September 2020. Enquiries were to be made with Centurion Health about his needs.

36. On 18 September 2020, Nurse Unit Manager Christine Hele made contact with a respiratory doctor, although it is unclear who that was. According to her note, she discovered that DP had not been given a prescription for a CPAP machine in the community. Instead, he had been trialling a machine, but had not attended the hospital appointment to receive a prescription. Enquiries were made with Enable NSW to seek funding for a machine, however it was now clear that DP was going to need a review by a respiratory physician in order to get a prescription. Unfortunately this appears to have been the first time that health practitioners identified that DP did not have the appropriate prescription.

37. On 28 October 2020, a referral was sent to John Hunter Hospital for a sleep clinic review. DP was informed that it would take time to get the necessary appointments. In December, further information was sought from Dr Abbott, but he could not be contacted.

38. DP eventually received a telehealth appointment on 19 January 2021. He was reviewed that day by Dr David Arnold, a respiratory and sleep medicine specialist. He drafted a letter to JHFMHN, although it does not appear it was sent, or at least not received prior to DP's death. The report confirms DP had severe obstructive sleep apnoea. He would need an overnight stay for an assessment and then a trial.

39. A follow-up appointment was booked, initially for 22 April 2021, but DP died before it took place.

40. As that brief summary of events shows, DP did not receive access to a CPAP machine for over 9 months, from when he first raised the issue in July 2020. In my view the evidence establishes that it had a negative impact on the quality of his life. He found the effects of sleep apnoea debilitating. He reported that his snoring was upsetting his cellmates. He reported that the lack of sleep gave him headaches, poor concentration, memory issues, and made his depression worse. [7]

41. Dr Sullivan told the court that DP's sleep apnoea is likely to have led to impaired sleep, high blood pressure, daytime somnolence, and fatigue, and to have exacerbated anxiety or mood disorder, including depression. Dr Sullivan stated that "*I think DP made the link himself in consultation with various clinicians that his poor sleep quality impacted on his mood during the day. That is, I think, plausible and consistent with what we understand about the effects of chronic physical health disorders upon mental health and wellbeing.*[8] *Patients with these disorders tend to complain of a range of non-specific non-physical ailments or impacts on their wellbeing… I consider it fair to say that it is likely obstructive sleep apnoea, when untreated, has a negative impact.*"[9]

42. It is clear that DP began to report symptoms of depression. On 8 September 2020, he was prescribed an antidepressant, Cymbalta or duloxetine. On 12 October 2020 he submitted a form, asking for his medication to be reviewed, as he was still suffering from depression.

43. He was booked for a mental health review, and was seen on 9 November 2020. He told Nurse Belinda Weston that he attributed his depressed mood to not having a CPAP

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[7] Tab 140: PSRF 31 August 2020, Tab 141: PSRF 12 October 2020, Tab 181(KK) Progress note dated 19 December 2020

[8] T13/09/2023 21.12

[9] T13/09/2023 22.5-13

machine[10]. He denied thoughts of self-harm, but the nurse discussed a safety plan with him.

44. On 8 December 2020, he submitted a form seeking help with his anxiety. He was reviewed two weeks later, on 22 December 2020. The impression of Nurse Twomey was that his physical health concerns were impacting his mental health. He again said he had no intention of harming himself.[11]

45. He was also seen by a psychologist on 12 January 2021. He reported difficulties with his sleep and ongoing rumination. However, the referral was closed, with a plan that DP would contact wing officers if he needed further support.

46. At the end of December 2020, DP had put in a request to transfer to a gaol where he could work. He said he felt this would ease his stress and depression and make the days pass more quickly. He was subsequently transferred back to Parklea Correctional Centre.

The second period at Parklea Correctional Centre, January to April 2021

47. DP was transferred to Parklea on 30 January 2021.

48. On his arrival, DP was screened at reception. He reported no thoughts of self-harm.

49. He was placed in cell 18, in Area 1D. He remained there until his death. He was housed, on his own request in an area for protective custody for Special Management Area Placement inmates. DP reported that he had been assaulted by another inmate and did not feel safe. Overall, he was assaulted a total of three times in custody.

50. On 2 February 2021, DP obtained work in the industries at Parklea, in the laminating section of the cabinet workshop. He was regarded as a quiet but hard-working inmate. He worked 35 hours a week, five days per week. He progressed to being a trusted level seven mentor inmate.

51. At some point in the weeks prior to his death, DP's state of mind deteriorated. There is no record that indicates he directly reported suicidal feelings to anyone at any point, but with hindsight it is clear that he began to take steps which may now indicate that he had formed an intention to end his life.

52. Having reviewed the material Dr Sullivan expressed the opinion that there is insufficient evidence to identify any single event or circumstance that triggered his suicidal intention. I accept that view and acknowledge the decision was likely to have been multi-factored.

53. DP raised no concerns about his health during this period. He had been vocal about his need for support during his earlier time in Parklea and at Shortland Correctional Centre.

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[10] Tab 181(MM): Progress note dated 9 November 2020

[11] Tab 181(MM): Progress note dated 23 December 2020

But there were no forms submitted after December 2020, and only incidental interactions with health services during February and March 2021.

54. In late February 2021, DP was charged with further offences. His case was mentioned at Burwood Local Court.

55. On 12 March 2021, DP sold his property, and confirmed with his sister that the funds were available.

56. On 25 March 2021, he prepared a will. The inmates who witnessed this document did not recall any explicit indications of self-harm, at that point, although in retrospect they reported that they observed him to be more moody. He told one of them, later, that he would not be able to witness their document saying, "*I won't be around*", although the comment was ambiguous and did not raise particular concern at the time.

57. DP also took other steps to put his affairs in order, for example having his boat registration paid and checking his superannuation beneficiaries.

58. On 29 March 2021, he wrote a letter to his lawyer, asking her not to apply for Supreme Court bail, and not to act for him further. This is noteworthy in the context of his former interest in his legal affairs and upcoming trial.

59. DP made several calls to his partner in the days before his death. They speak of his depression, and he complained about the lack of support he was receiving. However, he made no indication to her that he intended to harm or kill himself.

60. Tragically, after DP's death, a number of letters were discovered in the outgoing mail system at Parklea. These were addressed to his sister, partner and solicitor. One letter to his partner included the words "*I am sorry for me leaving. Please forgive me. I will always try to watch over you.*"

Events leading up to DP's death

61. At the time of his death, DP was sharing a cell with a new inmate, [redacted], who gave evidence before me. [redacted] had only been at Parklea for a couple of weeks. There is no evidence of any issue between them. [redacted] gave evidence that he '*got along well'* with DP and that he found DP '*pretty quiet, respectful'* and '*seemed like a pretty normal sort of guy'*[12]

62. A couple of nights prior to DP's death, [redacted] heard what sounded like sheets being torn. DP had also hung a sheet across his lower bunk bed, to create a screen.

[12] T12/09/2023 3.18-32

63. The court heard that the practice of using sheets for privacy is well known in the custodial environment. Malcolm Brown, General Manager of Statewide Operations, CSNSW, gave evidence that *"it is common for inmates to use linen as privacy screens.*[13] In relation to the fact that this practice contravenes CSNSW policy, Mr Brown said *"it is a challenge and I think compliance is an issue in relation to that, but it's about least restrictive care, and providing an inmate in custody with the level of privacy and decency and respect that they are entitled to"*.[14]

64. On Easter Sunday, 4 April 2021, the two cellmates were locked in at about 3.30pm. That evening, they watched TV, including a World War II documentary. At about 8.30pm, his cellmate handed DP the TV remote and went to sleep. [redacted] says he slept through the night, until he was woken by guards the next day. [redacted] told the Court that in the morning "*I just heard them call out to him a couple of times and then they said 'he's obviously not coming', and I didn't really think much of it, being Easter and that.'*[15] *So I was sort of laying down half asleep until I heard the other officers unlocking the doors.*[16]

65. There had been checks made of the cell door during the night, but no-one opened the door until the following morning.

66. At about 7.20am, Correctional Officers Mark Ward and Guy Blinman approached the cell. They were letting inmates go for work. They were not conducting a "*let go*" of the other non-working inmates. The situation was a little unusual as it seems that most previous Easters work had not been conducted. Officer Ward told the court "*this was the first time we'd operated on a public holiday*."[17] He was also under the impression that because it was a public holiday "*if they didn't want to work that was quite all right."*[18]

67. Both officers gave evidence before me. The court heard, Officer Ward cracked the door and looked inside. A sheet was hanging across DP's bunk bed. Officer Ward said, "DP*, are you coming to work?"* He received no response, and asked again. He then says he saw a hand come out from under or next to the bedsheet. He took that to mean DP was not coming out, and he marked him absent and moved on.

68. Officer Ward told the court "*I believe I seen what I seen*", but accepted that in hindsight he may possibly be mistaken. He stated "*but at the time I was sure. I'd seen the inmate on the top bunk, he had – he'd drawn my attention because he turned and looked at me, and then*

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[13] T12/09/2023 13.41
[14] T12/09/2023 14.16-19
[15] T12/09/2023 6.40-42
[16] T12/09/2023 8.22-23
[17] T11/09/23 33.47
[18] T11/9/23 38.50

laid down, and then I just automatically looked, and I believed the sheet moved with the hand."[19]

69. He then told Officer Blinman that DP was not attending. Officer Blinman did not see DP raising his hand.

70. Officer Ward was asked about his understanding of his obligations that morning. The relevant job description and policy was the subject of evidence and is an issue to which I will return. Officer Ward gave his evidence in a straightforward manner and did not resile from his position that he believed at the time he had seen a hand. I have considered the matter carefully and am of the view that he must be mistaken. I have taken into account the evidence of Dr du Plessis[20] and the fact that rigor mortis had been established by the time paramedics arrived shortly afterwards, making it highly implausible that DP hanged himself some time *after* Officer Ward left the cell entrance. Given the position in which DP was found, I find it most unlikely that Officer Ward *could* have seen a hand. I had the opportunity to observe Officer Ward as he gave evidence and did not form the impression that Officer Ward was lying or attempting to mislead the court. Given his understanding of his obligations at the time, it seems likely his opportunity to make an observation was quick and that ultimately he is mistaken about what he saw. It is possible he saw the sheet move because of ’s movement on the top bunk and he interpreted that movement incorrectly.

71. About 45 minutes later, at 8.06am another officer, Henry Toma, came to conduct the let go. He opened the cell door. He moved the sheet and saw DP lying face down on the mattress. DP is described as having had his arms and hands tucked under his chest, and his feet bound with another piece of sheet, cut into lengths. The same material was wrapped around his neck. He was blue/purple in colour and had blotches on his skin.

72. Officer Toma called for help, and Officer Whiteis called an emergency Code Blue. The ligature was cut, and the officers moved DP to the floor. They commenced chest compressions.

73. Nursing staff attended at 8.12am. Paramedics were on scene by 8.28am. However, it was apparent that DP was already deceased, and they did not render further medical assistance.

74. According to the paramedics, DP had already developed rigor mortis, indicating he had been dead for some time.

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[19] 11/9/23 38.29-34

[20] Tab 2E: Supplementary report of Dr Marna du Plessis 7 September 2023

Medical cause and time of death

75. An autopsy was conducted by Dr Marna du Plessis on 9 April 2021 at Forensic Medicine, Sydney. Dr du Plessis noted the ligature abrasion around DP's neck. A post mortem computed tomography (CT) scan showed an angulated fracture of the hyoid bone which was also in keeping with hanging. Toxicological analysis detected no alcohol. Non toxic concentrations of paracetamol and quetiapine were detected. I accept her opinion that his cause of death is hanging.

76. Dr du Plessis was unable to make a determination on the exact time of death. I accept her opinion that any such determination would be "*fraught with difficulty and a multitude of variables with unreliable outcomes.*"[21] However in a later supplementary report provided to the court Dr du Plessis noted that forensic literature usually described the average time for rigor mortis to have set in as being approximately eight to 36 hours.[22] Given DP was seen alive by his cell mate around 8.30pm on 4 April 2021 and was described as cold and stiff by Correctional Officers Whiteis and Toma just after 8am the following morning[23], it is in my view extremely unlikely that he was alive when Correctional Officer Ward believes he saw a hand less than one hour before. However it remains impossible to say whether DP died in the evening of 4 April 2021 or in the early hours of the morning of 5 April 2021.

Manner of death

77. A finding that a death is self-inflicted should not be made lightly. The evidence must be cogent and persuasive. I am satisfied that in this case the manner of death should be recorded as intentionally self-inflicted. There is extensive evidence to support this finding. There was considerable planning in relation to the action he took including writing a new will, arranging his financial and legal affairs, sending final communications to people he was close to and preparing his sheet to make a ligature.

78. The evidence establishes that DP was likely to have been struggling with his mental health for some time. I accept Dr Sullivan's evidence that it is impossible to identify "*any single, clear precipitant to his plans*".[24] As Dr Sullivan points out, "*he was facing a whole range of stressors*" including a murder charge. It is impossible to determine how each was affecting him.

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[21] Tab 2E: Supplementary report of Dr Marna du Plessis 7 September 2023
[22] Tab 2E: Supplementary report of Dr Marna du Plessis 7 September 2023
[23] Tab 25: Statement of Henry Toma para 8, Tab 31: Statement of William Whiteis para 18
[24] 13/09/23 T27.12-14

Discussion of Issues

The system of patient self-referrals

79. It was submitted that DP was frustrated by the self-referral form system. For this reason Counsel assisting put forward a draft recommendation asking SVCH to consider enhancing the system of patient self-referral at Parklea Correctional Centre, to include access to appointments via telephone.

80. Counsel assisting drew the court's attention to the fact that DP submitted 19 Self Referral Forms (SRFs) requesting medical attention during his first period at Parklea and a further five at Shortland Correctional Centre. In my view the large number of forms during a relatively short period *could* indicate a lack of satisfaction with the process. There is certainly evidence that DP was frustrated at various times at the speed with which his issues were addressed.

81. Evidence that DP was frustrated can be taken from comments on various SRFs, including *"I have put in patient self-referral forms before about this but have not been spoken to about it. I am suffering greatly from this problem, and I am having great difficulty dealing with the stress it is causing me"*[25]; *"I have made continuous requests for the CPAP machine as I have severe sleep apnoea"*[26] and *"requested to see doctor in June for pinched nerve L4/L5 in spine and for severe sleep apnoea. I suffer in great pain and heart working too much from airway being cut off. PLEASE ESCALATE"*[27].

82. The court received information from Ms Therese Sheehan, Deputy Director of Nursing and Midwifery, Custodial Health, JHFMHN, about JHFMHN's Patient Health Enquiry (PHES) Project/Patient Self Referral (PSR) pilot. She told the court that a formal review of the PSR process, conducted in 2018 recommended the implementation of a Patient Self-Referral Call Centre, staffed by four registered nurses. The system used the Offender Telephone System (OTS) to enable patients to self-refer health problems in real time.[28] The PHES project commenced in February 2023, in six correctional centres. At the conclusion of the pilot on 30 June 2023, a total of 1, 952 PSR phone calls had been answered. Ms Sheehan stated that patients who spoke to the registered nurses overwhelmingly reported it as a positive experience and preferred it to using the paper PSR form. As at August 2023, the PSR phone service is still operational at the six pilot centres, with further expansion to be considered based upon ongoing funding for the project.[29]

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[25] Tab 143: Patient Self Referral Form dated 10 December 2020
[26] Tab 190: Self Referral Request dated 21 July 2020
[27] Tab 195: Self Referral Request dated 3 August 2020
[28] Tab 185: Statement of Therese Sheehan paragraph 13
[29] Tab 186: Supplementary Statement of Therese Sheehan paragraphs 6-8

83. Given the positive feedback, the court was keen to recommend SVCH *consider* a like scheme.

84. SVCH opposed the recommendation, asserting that it did not arise from the factual circumstances of DP's death. SVCH submitted that there was no evidence to suggest any inadequacy in the way that SVCH reviewed, triaged or actioned DP's SRFs. Further it was submitted that there were other methods available to custodial patients to voice health concerns such as when SVCH staff conducted medication rounds or referrals to the Official Visitor. SVCH submitted that DP was well able to express his need for a CPAP through his own requests and through requests made by his sister and his lawyer.

85. SVCH also submitted that there would be funding and feasibility challenges to implementing the recommendation. It submitted that Parklea faces unique challenges as a reception and remand facility and for that reason is exposed to a higher number of initial complaints and medical concerns than some other facilities.

86. In my view it was a disappointing response. There is clear evidence that DP found his constant self-referrals dispiriting. I had hoped there would be a willingness to give further *consideration* to the proposal in the light of the positive evidence of Ms Sheehan that JHFMHN would like to expand the program[30], and that feedback about the program has been '*mostly positive*'.[31] It is not hard to see that for many prisoners actually talking to someone about their concerns would be preferable to filling out a form and not knowing whether their concerns have been understood or getting a clear sense of what will happen next.

87. It appeared to be primarily a funding or resource concern. It seems to me that if private providers are unable to even *consider* ideas which appear to be working in the public sector then contracts need to be reviewed. Those inmates residing in private correctional centres have the same rights as those housed in state run facilities, and should be provided with commensurate service.

88. I intend to make the recommendation for further consideration and send a copy of these Findings to the NSW Minister for Health and the NSW Minister for Corrections for their information about these important issues.

Care and supervision given the known history of depression

89. Dr Danny Sullivan told the court that DP received "*generally appropriate treatment*" for his mental health conditions through both providers (JHFMHN and SVCH). DP was reviewed by a general practitioner and had been prescribed an appropriate antidepressant

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[30] T13/09/2023 11.20
[31] T13/09/2023 12.16

medication in an appropriate dosage. He had several good quality assessments by experienced nursing staff.[32] Dr Sullivan gave evidence that within the limitations of resources across correctional systems in NSW, the assessment by psychologists was '*quite appropriate*'.[33]

90. Dr Sullivan was however of the opinion that these reviews of DP elicited clear features of ongoing symptoms of mood disorder, and as such they warranted referral to a psychiatrist to consider further treatment options. Dr Sullivan states that it is particularly salient given that DP had a history of psychiatric treatment, and that he had previously met a threshold for treatment for a clinically significant mood disorder, and that treatment had not yet been effective.[34]

91. Dr Sullivan told the court that he did not think a psychiatric review would have *necessarily* changed the outcome, however, when a person had not responded to a treatment and has complex medical issues, with multiple unusual medications, psychiatric expertise would be beneficial. He noted that if a person in these circumstances was being managed in the community, he would expect that a general practitioner, after trying for some time with medications, would seek to refer a person to a psychiatrist for further opinion and for advice of their management going forward.[35] I accept Dr Sullivan's views on this issue. I also accept that Dr Sullivan did not say that review by a psychiatrist, if it had taken place, *would* have prevented DP's death.[36]

92. Dr Sullivan noted that it did not appear that health services sought appropriate collateral information about DP's mental health care, including opinions of various consultant psychiatrists who had reviewed or treated him in the past. The court was advised that this information would have made it clear that DP had a long-standing history of psychiatric contact; had tried a number of different treatments, and perhaps had a longer history than might have otherwise have been appreciated. However, Dr Sullivan was not certain that this information would have impacted on DP's treatment in prison, or whether it would have altered the medications that were chosen or indeed altered the diagnostic formulation that was made at the time.[37]

93. I accept Parklea has some positive systems in place to support inmates who may be at risk of self harm or suicide. The court received information about two such programs.

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[32] Tab 9: Report of Dr Danny Sullivan paragraph 78
[33] T13/09/2023 26.8-13
[34] Tab 9: Report of Dr Danny Sullivan paragraph 80
[35] T13/09/2023 25.30-33
[36] T13/09/2023 25.27-28
[37] T13/09/2023 23.45

94. One system in place at Parklea is the Blue Dot program, which identifies inmates with significant risk history of self harm. A psychologist determines who is marked as a blue dot inmate, and custodial officers will be notified in order to maintain closer observation of those inmates for behaviours that might indicate increased risk of self harm.[38] The inmate's muster cards are identified with a blue dot, and a case officer is assigned to the inmate to check in with them regularly. Mr Brian Gurney, General Manager of Parklea, told the court that he believes the program has been successful and works well.[39] Unfortunately it appears that Parklea did not know DP was at serious risk. I accept that he had not disclosed suicidal ideation to medical staff.

95. The second system in place at Parklea is the Peer Listening Program. This was described as a training program for inmates to become peer listeners, so they are better equipped to provide support (but not counselling or advice) to other inmates.[40] It is an official job for which inmates, who then "*lend an ear*" to their fellow inmates. It is accepted that inmates can have a better understanding of what other inmates are going through, compared to custodial staff. Generally, the peer listening inmates will attend the reception rooms and speak to inmates when they first come into custody.[41] The Court was advised that a total of 1,153 inmates have completed the peer listening program as at the date of the inquest. There was no evidence before me that DP had contact with a relevant peer listener. Nevertheless the program sounds a good one.

Sufficiency of checks in the hours prior to death

96. As I have stated, in my view the evidence established that Correctional Officer Ward was most likely to have been mistaken in his memory of having seen DP's hand. In my view, taking into account the forensic evidence, it is much more likely that DP was already dead when the officer approached the cell. The position of DP's body would have excluded the possibility that his hand could protrude from behind the sheet in the manner described. Had the officer insisted on a verbal response, it is my view that DP would have been found slightly earlier, but his life would not have been saved. Nevertheless the court was concerned to understand the obligations officers have in these kinds of situations.

97. The court was supplied with a policy document entitled "Statement of Duties Custodial Officer Carpentry & Print Workshop" (Rev 1 dated 30 June 2019).[42] On its face it appeared to be the relevant statement of duties governing Mr Ward on the morning of DP's death.

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[38] Tab 132: Statement of Paul Baker para 83
[39] T12/09/2023 35.20-33
[40] Tab 132: Statement of Paul Baker para 84
[41] T12/09/2023 38.35-40
[42] Tab 132: Statement of Mr Paul Baker (Annexure 11), Tab 177 and also at Tab 108

That policy outlined an obligation on relevant officers to check for "*alertness*". The policy states "*open the cell door, enter the cell and call the inmate(s) by their name(s). If an inmate does not provide an appropriate verbal response, rouse the inmate and talk with him until satisfied that the inmate is alive and well. If an inmate does not readily respond to the name being called after repeated attempts to rouse him and it appears that the inmate is in distress, sick or not acting in a normal manner, initiate and render assistance.*"[43]

98. Mr Ward gave clear evidence that he had not seen this statement of duties as at 5 April 2021. Subsequently Mr Gurney gave evidence that notwithstanding the date recorded on the policy he could not say whether the statement of duties had actually been implemented as at 5 April 2021. Further it was apparent that the preceding March 2019 policy[44] did not mandate a verbal response. While the March 2019 policy refers to the Parklea Operating Procedure 4.18 Inmate Accountability Rev 1 (POP 4.18), a verbal response is there expressed using recommendatory rather than mandatory language.

99. Ultimately, I accept Mr Ward's failure to insist on a verbal response did not constitute a breach of his written obligations at that time. I also accept that the circumstances were somewhat unusual, given that it was an Easter holiday and it appears that numerous inmates did not present for work in the usual manner.

100. Officer Ward gave evidence that he was now aware that the policy requires a verbal response. Nevertheless at times a visual response is still acceptable as some inmates "*aren't that keen to talk to you*." He told the court in that case one might ask for a particular movement as a response, for example "*move a leg mate*."[45] He told the court he had received some training in the new policy and that if he had his time again he would "*remove the sheet. Point blank*. "He considered what had occurred a "*matter of regre*t".

Screening of inmate mail

101. The court was keen to understand if there were any mechanisms which could have alerted authorities to DP's declining mental state and plans to end his own life. After DP's death it became clear that letters written, but not yet received, by his partner, sister and solicitor contained information which might have alerted them to his suicidal plans.

102. CSNSW Custodial Operations Policy and Procedure (COPP) 8.1, *Inmate Mail,* says that whether outgoing mail must be opened, inspected, and read is at the discretion of the Governor.

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[43] Tab 108: Parklea Correctional Centre, Statement of Duties, Custodial Officer Carpentry & Print 30 June 2019, Page 2
[44] Tab 107: Parklea Correctional Centre, Statement of Duties, Custodial Officer Carpentry & Print 31 March 2019
[45] 11/9/23 T 46.45 onwards

103. MTC-Broadspectrum Parklea Operating Procedure (POP) 5.13 *Inmate Technology and Communication* which was current at the time of 5 April 2023, said in respect of inmate mail inspection:

(1) To open, inspect, read and copy the contents of any letter or parcel sent to or from an inmate designated as a National Security Interest (NSI) Inmate by the Commissioner and send a copy of it to the Parklea Intelligence Unit;

(2) Open and inspect all letters and parcels (except privileged communications) addressed to an inmate; and

(3) Ensure all mail sent by inmates is inspected.

104. In practice, outgoing mail from inmates on the mail monitoring list is taken aside and reviewed by the Parklea Intelligence Unit, but outgoing mail is not otherwise inspected as a matter of course. Additionally, the requirement to inspect all outgoing mail has now been removed, so that POP 5.13 aligns with CSNSW COPP 8.1.[46]

105. Brian Gurney advised the Court that monitoring inmate's mail or phone calls is done sometimes, "*but it's not necessarily by policy or by normal practice*" at Parklea[47]. It only occurs on a case by case basis.

106. Several arguments were put forward as to why it would not be feasible to monitor all outgoing mail at Parklea Correctional Centre:

(1) The volume of mail outgoing from the centre is usually between 120-200 outgoing mail items per day, increasing in peak seasons.[48] A large volume of resources would be required to check all the mail.[49]

(2) There are many diverse language groups housed at Parklea, and many letters are not written in English. It would not be feasible to translate every item of mail, so if all outgoing mail was to be monitored it would need to be in English only. At present, POP 5.13 only requires NSI inmates to correspond in English.

(3) Corrections and administrative staff are not generally qualified to make an informed assessment as to whether an item of mail will reliably indicate whether an inmate is at risk of self-harm. [50]

107. I accept there are cogent reasons for not screening all inmate mail.

[46] Tab 132: Statement of Paul Baker para 75
[47] 12/9/23 T33.47
[48] Tab 132: Statement of Paul Baker para 76
[49] T12/09/2023 33.8
[50] Tab 132: Statement of Paul Baker para 76

Provision of medication and the CPAP machine

108. At the time of his death DP was still waiting for a CPAP machine. Evidence revealed an explanation for the lengthy delays as follows:

(1) On 3 July 2020, DP advised SVCH staff that he had used a CPAP machine in the community. SVCH, in attempting to obtain a CPAP machine, were operating under the impression that DP had a prescription for the CPAP machine and began by attempting to obtain his CPAP machine from the community.

(2) On 15 July 2020, Enrolled Nurse (EN) Margaret Lawler documented that an MTC Officer confirmed that the CPAP machine was not in DP's' possession, that DP did not know where it was, and did not know anyone in the community who could help locate the machine.

(3) EN Lawler made attempts to obtain a new machine through Resmed in July 2020, but was unsuccessful as they needed more information about the type of machine and patient specifications. SVCH could not glean this information from DP, of from any ROIs that were issued.

(4) On 24 July 2020, EN Lawler contacted CPAP Consumer Care regarding ordering a new machine, but they advised there was difficulty in starting a new account for a custodial patient without his personal details, which SVCH could not provide due to confidentiality requirements.

(5) On 11 August 2020, EN Lawler contacted St Vincent's Hospital to discuss the possibility of them sending a CPAP machine to Parklea, however, St Vincent's Hospital did not have a machine available to send.

(6) On 12 August 2020, EN Lawler contacted MTC again, about locating DP's machine in the community. MTC advised that DP was in a rehabilitation facility prior to entering custody, and had some belongings in storage. The facility refused to go through DP's personal belongings, and DP had no access to the storage unit. Prisoners Aid were also unable to assist.

(7) On 24 August 2020, EN Lawler discussed an alternative treatment plan with Dr Tattersall, noting that avenues for obtaining a CPAP machine had been exhausted.

(8) On 28 August 2020, DP was transferred to Shortland Correctional Centre. [51]

(9) On 18 September 2020, Nursing Unit Manager (NUM) Christine Hele noted that DP advised he required a CPAP machine. NUM Hele contacted VOC and Westmead Sleep Centre to obtain his prescription. Later that day, NUM Hele noted that DP's'

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[51] Tab 226: Statement of Julie Dyer paras 25-43

respiratory doctor advised that DP had not been given a prescription as he was trialling a CPAP machine on hire.

(10) On 25 September 2020, NUM Hele made an application to Enable NSW for a CPAP machine.

(11) On 28 October 2020, Justice Health sent a referral for DP to be reviewed by a respiratory and sleep physician and John Hunter Hospital. DP attended this appointment with Dr David Arnold on 19 January 2021.

(12) On 27 January 2021, Dr Arnold wrote to Justice Health advising that DP had severe obstructive sleep apnoea and that to arrange the CPAP machine from Enable NSW, he would need to have an overnight stay in the sleep unit. Unfortunately, it is unclear where this letter was sent, as it was only uploaded to the Patient Administration System (PAS) after DP's death, and Justice Health advised they only 'recently' obtained a copy of this letter.[52]

(13) On 30 January 2021, DP returned to Parklea. He returned with future appointments booked with the John Hunter Hospital Sleep Disorder Clinic on 22 April 2021 and 6 June 2021. SVCH were not notified of these appointments, but the court heard that this is not unusual, as in the days prior to the appointment, MTC would be contacted about making arrangements for attendance at the appointment.[53]

109. Katya Issa, Operations Manager at SVCH agreed at the inquest that it would have been desirable to identify that DP required a specialist review, and steps should have been taken to obtain the review while he was at Parklea.[54]

110. Julie Dyer, Nurse Manager at SVCH told the court that DP was in an unusual position of having told SVCH that he had a CPAP machine in the community but did not have any details of a prescription and could not access his machine. Despite the fact that DP told SVCH that he didn't use a mask, he used a nasal tube, the pressure setting was 20 and the brand was Phillips, this was not enough information to obtain a machine from St Vincent's Hospital, and in any case, the initial decision was to try and locate the CPAP machine that DP used in the community.[55]

111. Ms Dyer noted that DP had a compliance period when he had a CPAP machine in the community but was in the middle of the process of having the machine allocated and prescribed to him. He did not attend the appointment to '*finish off that loop*'. She explained that DP may have thought he had a CPAP machine in the community but it was not

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52 Tab 185: Statement of Therese Sheehan paras 26-27
53 Tab 226: Statement of Julie Dyer para 52
54 T12/09/20203 52.45
55 T12/09/20203 57.10, 59.30

actually finalised with him and he still required a final prescription for ongoing treatment.[56] It strikes me that many prisoners might not understand the crucial difference between trialling a machine and having a valid prescription for one.

112. Ms Dyer agreed in retrospect that efforts could have been made to obtain a specialist appointment for DP while he was at Parklea. However, she noted that it is always best practice to try and get the patient's own CPAP machine first.[57]

113. Given the ongoing stress the issue caused DP, the Court was keen to understand if there had been improvements in the available systems which would provide inmates like DP with a prompt medical response to sleep apnoea.

114. There was clear evidence that JHFMHN now has improved systems in place. The JHFMHN *CPAP Guidelines for the management of patients requiring CPAP machines while in custody* (CPAP guidelines) provides for the provision of CPAP machines to patients on an as needs basis by ordering the machine from a supplier.[58] The CPAP guidelines outline that:

(1) Before a patient commences with a CPAP machine they require a sleep study to determine if it is required, and if so, a prescription that is specific to the patients requirements will be developed.

(2) If a patient has an existing prescription, they do not require another sleep study unless medically indicated. For these patients, an application is made to Enable NSW for a CPAP machine.

(3) For patients that do not have a prescription, a referral is made for the patient to have a sleep study completed.

115. At the time that DP was in the care of JHFMHN, there were no CPAP machines on standby. The Court received evidence that this has since changed, and ten CPAP machines were delivered in late 2022 as part of an '*equipment pool*'. The process set out in the CPAP guidelines is to apply to Enable NSW for a machine, and while waiting for that application to progress, a machine can be hired, or one of JHFMHN's machines can be used.[59]

116. Ms Sheehan gave evidence that the intention of having the stock is so that people who have a prescription and cannot access their own machine, or have not yet received a machine through Enable NSW, would be given a machine from stock until the Enable machine was provided. Then the hire machine could be returned to the stock pool.[60]

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[56] T12/09/20203 61.26
[57] T12/09/20203 63.11
[58] Tab 185: Statement of Therese Sheehan para 34
[59] T13/09/2023 6.46-48
[60] T13/09/20203 9.1

117. Ms Issa gave evidence that Parklea does not have any CPAP machines. If a person did not have their own machine, they would be put forward for a sleep study and respiratory appointment to start the process, unless they already had a machine in the community, in which case they would pursue a pathway of having that brought into to the centre. Ms Issa said that in an ideal world, they would love to have a stock of CPAP machines in the way that JHFMHN does, but the reality of being able to provide a stock machine in a timely fashion in a remand centre is '*quite challenging*.'[61]

118. In addition, Nurse Manager Dyer gave evidence that it is not possible for patients at Parklea to access JHFMHN stock CPAP machines, so if one was required, the patient would be transferred to a facility where the patient would be in the care of JHFMHN, which she said '*can happen very quickly*.'[62]

119. Nurse Manager Dyer further noted that if someone is in the care of JHFMHN, and is transferred to Parklea, they can take the machine they borrow from JHFMHN with them until the Enable machine arrives.[63]

120. This seems quite unsatisfactory, and I pause to note that some inmates such as DP might have reasons to be at a particular gaol, such as the provision of work (or proximity to family), and should not have to be moved merely to get access to basic medical equipment. I note that JHFMHN did not appear to accept that the need for a CPAP machine was an appropriate reason to transfer care. Ms Sheehan stated that she did not agree that Parklea should transfer a patient to the care of JHFMHN in order to access a CPAP machine, and expressed a view that Parklea should be able to provide, or hire a machine for patients until they are able to access their own machine.[64] I accept her view on this matter. If private health providers are involved in providing care to inmates, it cannot be a second rate service or one that relies on transfer to JHFMHN if care is considered too expensive. Transfer between gaols can be stressful for inmates and should only occur when necessary.

121. I intend to make the recommendation as drafted and provide a copy of these findings to the Minister of Health and the Minister of Corrections for their information.

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[61] T12/09/20203 51.3
[62] T12/09/20203 65.40
[63] T13/09/20203 9.20
[64] T13/09/20203 9.45

Hanging points in custody

122. Coroners have been concerned about hanging points in custodial environments for many years, frequently making recommendations for urgent change. [65]

123. Brian Gurney, General Manager of the Parklea Correctional Centre employed by MTC provided the court with information in relation to recent modification works at Parklea. He advised that Areas 4 and 6 are modern parts of the Centre which do not require modifications. Area 5 has undergone a program of modifications involving modifications to the position of stenofone points, shower rails, and beds. Areas 3B and C are a priority area for ligature point reduction and these areas are currently empty pending the proposed work. The work was estimated to commence in October 2023 and expected to take approximately six months to complete. Areas 1 and 2 are not presently programmed for ligature reduction works but rather, modifications are being made in these areas on an *ad hoc* basis as part of the maintenance program for those cells.[66]

124. The cell where DP was accommodated has not been refurbished.

125. Mr Gurney advised the court that although MTC is funded to maintain and operate the Parklea Correctional Centre, funding for ligature reduction works is dependent on obtaining funding approval under the Corrective Services NSW (CSNSW) Minor Capital Works Program.[67]

126. The court also received a statement from Mr Craig Mason, Assistant Commissioner, Contracts and Commissioning, CSNSW. He advised that since 2016 CSNSW has undertaken extensive works across a number of facilities to reduce the risk of self-harm and suicide. This is to be commended but the work must be ongoing.

127. In this statement, Mr Mason revealed that CSNSW has a program of cell refurbishment, where priority is based on risk assessments for vulnerable inmate groups, utilising historic data, and consideration of both the cohort risks and previous recorded locations of self harm incidents.[68] Removal of ligature points may include replacing cell doors, grilles, beds, basins and tapware.[69]

128. In his statement, Mr Mason advised the court that in the financial year 2022/23, approximately $2.4 million was spent on cell refurbishments including 120 cells at the

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[65] There are many recommendations over many years. See for example Inquest into the death of Kerry-Ellen (Nikki) Knight 28 September 2022. More recently hanging points have been considered in Inquest into the death of SH (16 August 2023), Inquest into the death of Matthew Grieve 15 August 2023
[66] Tab 133A: Supplementary statement of Brian Gurney paras 9-18
[67] Tab 133A [8]
[68] Exhibit 2: Statement of Craig Mason para 11
[69] Exhibit 2: Statement of Craig Mason para 12

Metropolitan Remand and Reception Centre (MRRC) (with 38 more commencing in June 2023); 114 cells in Blocks 5A, B and C of Parklea Correctional Centre, and 12 at Silverwater Women's Correctional Centre (with 8 more commencing in June 2023).

129. Finally, Mr Mason advised that $6 million was requested from capital funding to be carried forward to the 2023/24 financial year in addition to the Minor Capital Works funding. This request was approved, and will be used to facilitate further cell refurbishment works.

130. I accept that work is slowly being done to make NSW Correctional Centres safer. Nevertheless I am of the view that it is happening too slowly. I intend to make a recommendation in relation to this issue.

Findings

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

Identity

The person who died was DP

Date of death

He died on 4 and 5 April 2021

Place of death

He died at Parklea Correctional Centre, Parklea NSW

Cause of death

He died of hanging

Manner of death

His death was intentionally self-inflicted

Recommendations pursuant to section 82 *Coroners Act 2009*

132. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

133. Counsel assisting put forward three recommendations arising out of the evidence for the court's consideration. For reasons stated above I make the following recommendations

To St Vincent's Correctional Health

I recommend that

St Vincent's Correctional Health formalise a policy acquiring CPAP machines for inmates who require them in custody, including the source and funding of those machines

St Vincent's Correctional Health consider enhancing the system of patient self-referral at Parklea Correctional Centre, to include access to appointments via telephone.

To Commissioner Corrective Services

I recommend that

The Commissioner Corrective Services NSW should continue to seek additional funding for the program of cell refurbishment, to progress the removal of obvious ligature points from cells in correctional centres as a matter of urgency.

Conclusion

134. I offer my sincere thanks to counsel assisting, Mr Jake Harris and his instructing solicitors Catherine Moore and Bianca Holliday-O'Brien for their assistance in this matter.

135. Finally, once again I offer my sincere condolences to DP's family, especially his children.

136. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court, Lidcombe
16 November 2023