CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of JS
Hearing dates:	20 – 23 March 2023
Date of findings:	23 May 2023
Place of findings:	Lidcombe
Findings of:	**Magistrate Kennedy** **Deputy State Coroner**
Catchwords:	CORONIAL LAW – Cause and manner of death, death in custody, mental health, Justice Health waitlists
File number:	2020/135219

Representation:	Mr J Harris, Counsel Assisting, instructed by Mr N Albany, Crown Solicitor’s Office Mr A Booker instructed by Mr J Howell, McAneny Lawyers representing the JS family Ms P White instructed by Ms A Heritage, Department of Communities and Justice representing Corrective Services NSW Mr H Norris instructed by Ms K Hinchcliffe of Makinson D’Apice Lawyers representing Justice Health NSW Ms L Alexander, Nurses and Midwives' Association representing Registered Nurses K Fuller and C Crole Mr R Reitano instructed by Mr M Jaloussis, McNally Jones Staff Lawyers representing Senior Correctional Officer J Williams

Findings:	***The identity of the deceased*** JS ***Date of death*** 5 May 2020 ***Place of death*** Shortland Correctional Centre, Cessnock, New South Wales ***Cause of death*** Plastic Bag Asphyxia ***Manner of death*** Intentionally self-inflicted (in a custodial setting)
Recommendations:	**NIL**

INTRODUCTION

1. This is an inquest into the death of JS, who was 34 years old when he died on 5 May 2020 at Shortland Correctional Centre, while on remand.

2. The primary functions of this inquest are to determine the following pursuant to the Act:
   (a) The identity of the deceased;
   (b) The date and place of the person's death;
   (c) The manner and cause of the person's death.

3. Guided by these aspects, an inquest investigates the facts and circumstances of a death, places them on the public record and in certain cases will examine changes that could be made to prevent similar deaths in the future. An inquest is not a forum for the laying of blame or the attribution of guilt. Nor is it a vehicle for civil litigation. It is not a trial, but an inquiry.

4. In this case, there is no controversy as to JS' identity, date or place of his death. The inquest explored the manner of his death.

Background

5. JS died on 5 May 2020 at Shortland Correctional Centre, Cessnock. He was 34 years old. JS had entered custody on 4 February 2020, after being charged with serious offences and was bail refused. On 4 May 2020, he was granted Supreme Court bail, on conditions including a $1 million surety and a requirement to surrender his passport. His parents attended the gaol at about 7.25pm on 5 May 2020 to collect his passport and to comply with the bail requirements. Tragically, JS was found deceased in his cell shortly afterward they arrived to collect his passport and to make arrangements for his release.

The nature of an inquest

6. An inquest is required and in fact mandatory to be held into JS' death, because his death occurred while he was in a correctional centre (s. 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009*).

7. This is important because JS was not at liberty to make arrangements to address his own physical and mental health, and relied instead on the State who is responsible for ensuring that he received reasonable and adequate care and treatment where necessary. The focus of the inquest was to look at individual contributions to the care of JS, but the major focus was the policies and systems in place.

8. I note that it is not the purpose of an inquest to blame or punish anyone for the death. Neither is it any part of the Court's function to make findings about fault or negligence, or to award compensation.

9. The primary function of an inquest is to identify the circumstances of death. At the conclusion of this inquest, I am required by section 81 of the *Coroners Act 2009* to record in writing the fact that a person has died and also to record:
    a. the person's identity;
    b. the date and place of the person's death; and
    c. the manner and cause of death.

10. There are five questions to be answered, however the only matter in issue in this case is manner of death.

11. Another purpose of an inquest is found in section 82 of the Act, and that is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from JS' death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances. Without limitation, that includes matters of public health and safety, or that a matter be investigated or reviewed by a specified person or body.

Background to JS

12. JS was born at the Royal North Shore Hospital in 1985. He was the only child of BS and RS.

13. Prior to his arrest, JS lived with his parents at Balgowlah. His parents split their time between Balgowlah and their farm in Invercargill, New Zealand.

14. JS was musical, and a very talented musician. He attended St Andrews Cathedral School and then the Australian Institute of Music. During his adult life, he worked as a music tutor, and he also had roles in childcare. In 2019, JS commenced studying at the Sydney Wine Academy and had been working in Mudgee as a cellar door manager. He was studying to become a Master of Wine. He loved soccer and musical theatre and performed in local productions.

15. The inquest focuses on JS' time in gaol; however it is important to reflect on his life before that time, and in particular that he had a very special and close relationship with his parents. He was much treasured and loved. He had the gift of befriending easily and would remain connected with those he got to know. He was caring and generous by nature and had an impressive huge personality when with others. The effect JS had on those around him was evident. For example, when he passed away, the other inmates in his pod pooled together their precious money and had a magnificent arrangement of flowers and a card sent to his parents.

16. The material in the brief suggests that JS developed a problem with alcohol prior to entering custody, as JS self-reported that he would consume 2 bottles of wine daily. He also had a history of anxiety and depression. JS received some treatment for this in about 2008, and was prescribed antidepressants, but he had not received treatment since. He reportedly found the antidepressants made his symptoms worse. It should be noted though at the time of entering remand he was not receiving mental health treatment.

The criminal allegations

17. At 7.15am on 4 February 2020, JS was arrested at his home. He was taken into custody at Manly Police Station. He declined to participate in an interview. He was charged and taken to Manly Local Court, where he was refused bail.

18. The proceedings were later adjourned to 4 June 2020 for charge certification.

19. It is unnecessary to consider the alleged offences which resulted in JS entering custody in any detail. As a result of JS' death, those allegations were never tested at trial however it

is of importance to note that the allegations were serious. If proved, they may have resulted in a substantial prison sentence.

Time in custody

20. Counsel assisting prepared an uncontentious chronology of events which are set out below.

21. On 4 February 2020, JS was admitted into the custody of Corrective Services NSW (CSNSW) at Amber Laurel Correctional Centre, Emu Plains.

22. On 6 February 2020, JS was transferred to the Metropolitan Reception and Remand Centre (MRRC) at Silverwater.

23. At reception, he asked to be placed into a form of protective custody, PRLA or Protection Limited Association. He remained under that form of protection until his death.

24. During the reception process, JS gave conflicting information about his mental health background. He told a correctional officer (or 'CO') during an Intake Screening Questionnaire that he had no mental health issues and had never been treated or medicated for such issues.

25. However, he told a Justice Health nurse, during a Reception Screening Assessment, that he had been treated for anxiety and depression about 12 years prior in 2008 at Manly Hospital. He also disclosed he had tried to end his life by running into a wall, because he "*lost contact with a friend"*. However, he was not considered to be at risk at that time. JS also disclosed a significant history of alcohol use. A summary of that information was supplied to Corrective Services NSW.

26. That nurse also completed a Health Problem Notification Form or HPNF. An HPNF is a form which is used by Justice Health to communicate health information and recommendations to Corrective Services NSW, including recommendations about accommodation and observations. A total of five HPNFs were completed while JS was in custody.

27. The HPNF completed on 6 February 2020 stated that it was JS' first time in custody, that he may experience symptoms of alcohol withdrawal, and also that he had an eye

condition. It was recommended that he be placed in a medical observation cell until cleared by the drug and alcohol nurse.

28. Following this, JS was initially accommodated in the Darcy Place of Detention (or POD), an accommodation area in the gaol used for the assessment of inmates, often before they transit elsewhere.

29. JS was reviewed regularly by nurses over the next few days. He was also given diazepam (Valium) and thiamine, for the effects of alcohol withdrawal.

30. On 9 February, a nurse noted that JS' temperature was high and he was referred to primary care for urinalysis.

31. On 10 February, Nurse Nazeem prepared an HPNF, stating that JS had been cleared from medical observation and from Darcy by drug and alcohol. However, it recommended group cell placement until JS was cleared by primary care. A separate note explains that this was because JS' blood pressure was high.

32. A group cell placement is a term referring to either a two-out cell or a dormitory cell. It appears the thinking, at that stage, was that JS should remain in that type of cell for medical reasons, given his earlier temperature and raised blood pressure. There are no recorded concerns at that stage about JS' anxiety or a risk of self-harm.

33. JS was accordingly placed in a cell with another inmate. There is some evidence that he found placement with a cellmate to be supportive.

34. Pathology results were obtained later that day, and they revealed a suspected UTI.

35. The following day, 11 February 2020, another HPNF was completed by Registered Nurse Jacobs (or RN Jacobs). It states:

    Headache
    May feel dizzy
    Ringing in ears
    Flushed

36. And it gave the following recommendations:

    Cleared from Darcy by Drug and Alcohol and PHCN [primary health care nurse]

Group cell placement

37. That form is not within the Justice Health medical records, and there is no associated progress note by the nurse. It is unclear why there was still a recommendation for group cell placement. There was no mention of any concern about anxiety or a risk of self-harm.

38. It appears JS remained in a group cell placement for the next couple of months, until he was transferred to Shortland Correctional Centre.

Referrals to psychology and mental health

39. About a week after JS was discharged from detox, he made the first of a series of requests for assistance. At this time, he began to experience significant distress and sleeplessness and sought medication for this.

40. On 19 February 2020, JS completed a Justice Health Patient Self-Referral Form which is a form used by inmates to seek medical assistance. He ticked a box indicating he was "*feeling stressed*" and stated he was having issues with constipation and sleeplessness, and that he wanted to check some blood test results.

41. JS was reviewed in the clinic on 29 February 2020. His observations were taken, and he did not complain of any discomfort.

42. Two weeks later, on 13 March 2020, he completed a second Self-Referral Form. This time, he stated:

    I am increasingly feeling anxiety, at times severe. I have never been to jail before and the isolation from friends and family, worries about detention, the inability to use my brain for work or study and the general extreme nature of jail is making me feel stressed and afraid. With the lack of much else to occupy my time I can only think constantly about this situation and it is affecting me all day and also now in my sleep. I am requesting a small dosage of anti-anxiety medication to help with this.

43. The form was reviewed by a nurse that day, and JS was placed on a mental health waiting list, with a priority 3, indicating it was non-urgent.

44. Three days later, on 16 March 2020, JS completed a third Self-Referral Form. He stated:

I am increasingly struggling to cope with my situation. I am getting very little sleep (3 hrs per night), have no appetite and am experiencing chest tightness and breathing shortness from anxiety. I do NOT need an observation cell – that would be the worst thing for me – but I do need some help so I can focus, eat, exercise and get through the day and some help to sleep. I have not been on medication for many years but this is an extreme situation I never expected to find myself in.

45. That same day, JS was seen by Nurse Catherine Stone in the clinic for a mental health review. She was the Acting Nurse Unit Manager for the Hamden POD within MRRC. JS reported he had been experiencing poor sleep for 2 weeks, weight loss and poor appetite. He wanted something to help him sleep. He was teary at times when discussing his situation. However, he denied thoughts of self-harm. Nurse Stone placed JS on the waiting list to see a psychiatrist. She also offered a mental health review in 2-3 weeks. However, he was "*reluctantly agreeable*" to this, stating "*what's the point if you can't give me any medications*".

46. Nurse Stone also asked a correctional officer to refer JS to a psychologist.

47. On 17 March 2020, JS called the mental health line. He again asked for medication to help him sleep. The nurse attempted to explain techniques to assist with this but JS was seeking medication.

48. JS made a request to see a psychologist again on 20 March 2020. He stated he was very emotional, but had no thoughts of self-harm, and said he had no past issues with mental illness.

49. The next day, JS completed a fourth Self-Referral Form. He stated:

    Requesting refill of Panadol for headaches and still waiting desperately to see psychologist and psychiatrist

50. The form was assessed and marked to indicate JS was already on the waiting list.

Psychology session 23 March 2020

51. On 23 March 2020, JS was seen by Corrective Services psychologist, Jiajing Pan. The notes for this attendance are detailed. The psychologist recorded that JS was alert and lucid,

oriented to time and place, had no formal thought disorder, no perceptual disturbance and his speech was normal. He reported feeling low mood and felt anxious. He did not maintain good eye contact, although this improved during the session.

52. JS provided a history of experiencing anxiety and depression intermittently for over 10 years. He said had seen a psychologist over 10 years ago, and had taken an anti-depressant, which increased his rumination of negative thoughts. He reported that benzodiazepines were most effective but appreciated he would not get these in custody.

53. JS stated he had experienced "*passive suicide ideation*" but had no intention or plans to hurt himself. He also denied past self-harm, although this is not consistent with what he reported on reception.

54. JS identified his parents as supportive and protective, and stated his "*only wish*" was to be with his parents. This is certainly borne out by the telephone calls JS made in gaol – he made several hundred in total, and many to his mother, on an almost daily basis, who provided JS with a great deal of support. JS also said he was struggling with setting future goals, due to the uncertainty of his court matters.

55. JS was given some psychoeducation about anxiety and depression, and provided with a pen, for something to do. Mr Pan confirmed that JS was on the waitlist to be seen by a psychiatrist. The plan was to follow him up to review his mental health state and give him some coping strategies.

56. JS remained on the waiting list to see a psychologist, with a subacute priority, requiring a further review within 12 weeks. He was in fact seen 6 weeks later, on 5 May 2020.

57. JS also had a scheduled appointment with a Justice Health mental health nurse that day. He did not attend that appointment, perhaps because he was seeing the psychologist.

58. JS was seen briefly by a drug and alcohol worker on 1 April 2020. He was not seen by a mental health nurse again, or by a psychiatrist, prior to his death. The reasons for that will be explored in the evidence.

Transfer to Shortland Correctional Centre

59. JS was transferred to Shortland Correctional Centre on 9 April 2020.

60. On reception at that centre, he was interviewed by Senior Correctional Officer (SCO) Jack Williams. SCO Williams did not usually work at that location. He was placed at Shortland Correctional Centre for about 3 months at that time, due to staff shortages. It is worth noting that these events occurred during the early stages of the pandemic.

61. During the interview, SCO Williams completed a *Section 23: Reception transfer checklist*, asking JS a series of questions. JS appeared timid, however, he denied thoughts of self-harm or suicide.

62. It was SCO Williams' role that day to determine JS' placement in the gaol. He had some recollection of JS, but this was very limited.

63. SCO Williams noted JS' protection status. He determined that JS should be placed in a one-out cell, that is, on his own. He provided other officers a coloured cell card to indicate this decision, although he did not record his decision on the form. He believed this was an administrative process that others would use.

64. JS was taken to Justice Health, where he was reviewed by RN Catherine Crole. A note of her assessment records that JS again denied thoughts of self-harm or suicidal intent. He was also screened for COVID-19.

65. On 11 April 2020, JS completed a fifth Patient Self-Referral Form, this time for pre-existing back pain. He stated that it greatly upset his sleep and that he was "*hoping for some pain killers of any kind.* On 12 April, he attended the clinic about that issue, and was given paracetamol, ibuprofen and Coloxyl for constipation.

66. On 18 April 2020, JS completed a sixth Self-Referral Form, saying he was feeling stressed. He wrote, "*I really need to speak to a psych today if possible, I'm just not coping*". This note was marked "*Booked for r/v 20/4/20*".

67. On 19 April 2020, he completed a seventh Self-Referral Form, again stating he was feeling stressed. He said, "*Requesting to see the mental health nurse or a psych please, I'm having trouble coping*". This was marked "*Already on W/L for MH r/v*".

68. The next day, on 20 April 2020, JS failed to attend an appointment at the clinic. It is unclear why. However, he did see the Chaplain that day, who provided some pastoral support.

69. A psychologist also made a note that day that JS would be "*followed up under existing service line in order of workload priority"*. A further referral to psychology was made on 27 April 2020, stating JS was "*not coping, no outside help.*"

3 May 2020 incident

70. On 3 May 2020, there was an incident. At about 4.53pm, JS pressed a cell alarm and asked for help, telling officers his thumb was going purple. Officers attended JS' cell, found him in distress and called Justice Health.

71. Nurses Katharine Fuller and Laura Smithers attended. They found JS had tied a cable tie tightly around his thumb, which was causing it to discolour and was cutting into his skin. The cable tie was cut with scissors and a band aid was applied. JS told Nurse Fuller he was going for bail the following day and was stressed, and that he had been playing with the cable tie. JS denied that this incident was an attempt at self-harm.

72. JS was then taken to the clinic and placed in an assessment cell, monitored by 24-hour CCTV.

73. Nurse Laura Smithers completed an HPNF, noting that JS had "*increase stress due to recent event*" but that "*denies thoughts of self-harm / suicide*". The plan was to place JS in a camera cell as a precaution and for review the following day.

74. The relevant Corrective Services policy is *Management of inmates at risk of self-harm or suicide.* It applies to all staff, including correctional officers and Justice Health staff. Any staff member who determines that an inmate may be at risk of suicide or self-harm must immediately make what is called a Mandatory Notification. An Immediate Support Plan must be prepared, which might include placement in an assessment cell, such as the one JS was in. The policy also requires a Risk Intervention Team (or RIT) to convene, to interview the inmate, and to determine whether the person is at risk of self-harm, and to either develop a management plan or discharge the person back into the gaol. A

Mandatory Notification was not required to have been made for JS as he was not deemed to be at risk of suicide or self-harm by Nurse Smithers.

Supreme Court Bail

75. The next day, 4 May 2020, JS had a bail hearing in the Supreme Court before Justice Wright. Bail was granted with strict conditions, including a $1 million surety, a $50,000 security, daily reporting, a curfew, and surrender of JS' passport. He was also required to be in the company of his parents when released. Those latter two conditions were prerequisites for his release.

76. Following the bail hearing, at 11.43am, RN Jenni Cobeanou reviewed JS in the clinic. JS said he wanted to spend the night back in the POD with his friends. JS denied thoughts of self-harm. RN Cobeanou noted that this verbal response did not match his physical presentation. JS was "*standing at door, frowning, slumped and teary, minimal eye contact".* RN Cobeanou decided that JS should remain in the clinic with CCTV monitoring until he was released. Again, no Mandatory Notification was made.

Events of 5 May 2020

77. JS remained in the clinic overnight. At 8.38am on 5 May 2020, JS phoned his mother. They discussed the arrangements for JS getting bail, and about calling his solicitor. RS said JS would be seeing a psychologist. JS said he was being held in a "*punishment cell*". He expressed eagerness for his parents to come to the gaol that day.

78. At 8.56am, JS called his solicitor, James Howell. They discussed arrangements for releasing JS on bail. Mr Howell believed that JS understood he would be released that day, or the following day.

79. Correctional Officer (CO) Rachel Wettig was the officer assigned to the clinic that day. She had previously been the permanent clinic officer and had also been a coordinator for the Risk Assessment Team. She does not remember the day. However, the nurse on duty, RN Catherine Crole, recalls that CO Wettig asked her on more than one occasion to update JS' HPNF. It appears CO Wettig wanted to free up a place in the clinic, which had a high turnover of inmates. RN Crole could not attend to this immediately.

80. At 9.35am, JS saw Corrective Services psychologist Tegan Joyce in the clinic. According to Ms Joyce, he appeared calm, stable, oriented and presented normally.

81. Ms Joyce stated that JS was concerned that the cable tie incident would be seen as self-harm. He denied any immediate concerns about his mental health or wellbeing, and denied current thoughts, plans or intent to self-harm. He said he had been granted bail and was looking forward to returning home to Sydney. He asked to return to the POD, but Ms Joyce said this was a matter for Justice Health and the correctional officers.

82. Because JS was to be released that day, Ms Joyce closed the referral to psychology.

83. Following this, CO Wettig again approached RN Crole for an updated HPNF. According to a note made by the nurse, CO Wettig said JS was "*still ok*" and no concerns about self-harm were voiced by JS or the officer. JS was keen to go home.

84. RN Crole considered the request to be reasonable and so she updated the HPNF. However, she did not see JS, or review his file.

85. At 1.38pm, RN Crole completed an HPNF. It stated, "*nil significant health issues*" and recommended "*normal cell placement*". This is a term which refers to an inmate who can be placed either with other inmates or alone. He was returned to his one-out cell.

86. If JS had been on a RIT at this point, the decision making process around this determination would have been more structured.

Afternoon of 5 May 2020

87. At this time, all inmates in the gaol were locked in their cells, due to an incident that had occurred which did not involve JS. At 2.33pm, JS was given a meal.

88. At about 4.27pm, three officers, SCO Brad Van Montfoort, SCO Andrew Dutch and CO Adam Farrell, attended JS' cell. His parents were at that stage on their way to the gaol to collect his passport. The officers were going to obtain JS' consent to release his belongings to his parents.

89. After entering the cell, SCO Van Montfoort began to explain the bail procedure. However, JS became upset, saying "*what, aren't I getting out?".* He got to his feet, and he was warned that if he did not remain seated he would be "*gassed*."

90. SCO Montfoort explained that JS' passport needed to be handed to a police station or the Court, and that he would be released either today or tomorrow, depending on where the passport needed to be lodged. JS was informed he would be told as soon as they knew anything else. He appeared to understand this and calmed down. JS then completed a form requesting all his valuables be released to his parents.

91. SCO Dutch then had a brief conversation with JS. He asked if he was feeling okay, after what had happened the other day. JS replied that his thumb was sore, but he was otherwise okay. He said he was off to Sydney with his parents. That was the last interaction anyone had with JS before his death.

The death of JS

92. At about 7.25pm that evening, BS and RS arrived at the gaol to collect JS' passport. At the time they arrived at the centre, officers were performing an evening medication round in H block.

93. At 7.26pm, CO Kelley and CO Arnold went to cell 81. CO Kelley saw JS lying on the floor of the cell and kicked the door to get his attention. There was no movement.

94. CO Arnold opened the cell door and officers Stubbs, Roe and RN Saunders entered. JS was observed to have a plastic bag over his head, with a sock tied around his neck and also tied to a stool. The bag resembled one used for inmate buy-ups.

95. CO Roe cut the sock with a "911 tool" and RN Saunders, Nurse Farrell and Officer Stubbs commenced CPR. An ambulance was called. Other officers attended to assist, and the events were recorded on a handheld video camera.

96. Paramedics attended the centre promptly at 7.38pm. Resuscitation efforts were not successful, and JS was declared deceased at 7.59pm.

97. BS and RS were informed of their son's death at Shortland Correctional Centre.

98. Police Crime Scene Officers attended and searched the cell. They discovered a second white plastic had been bag tied around a fork that was wedged behind some shelves, and also a strip of material had been torn off a towel.

99. A note was also discovered written inside the cover of a paperback ("*The boy who came back from heaven*"). It read:

> *My beautiful, wonderful, dearest Mum and Dad. I am so incredibly sorry. I would have given anything to hold you tomorrow but I was tricked into saying something I shouldn't have. All I ever wanted was to love and be loved - with you that love is eternal. Take me to the farm. Love you forever, see you tomorrow XXXX JS*

Autopsy

100. A limited autopsy by way of external examination was conducted on 7 May 2020 by Dr Allan Cala. He records the cause of death as "*Plastic bag asphyxia".* Toxicology detected no drugs or alcohol.

101. It was also clear from the autopsy that JS had lost significant weight. He was 105kg at the time of his admission to custody, and weighed 83kg at the time of the autopsy, meaning he had lost about 22kg in 3 months.

EVIDENCE ANALYSIS

102. At the commencement of the evidence in the inquest, the Court was played two voice recordings from JS. At 2.21pm on 3 May 2020 just prior to the cable tie incident there was a recording with his mum and dad. He was telling his parents about the fact that they were about to lock the inmates in. He discussed with his parents that it was great to see them that day. They discussed the pending bail application which was to be heard on the following day. They exchanged warm sentiments, and he was given support from his parents. The recording disclosed a very strong bond between he and his parents, and demonstrated how very close to his family he was.

103. A second recording was played from 8.39am on 5 May 2020, the context being the day of his death following a successful bail application on the day prior. His mother talked to him about the application, and the steps that his parents were taking to get him

released now that the Supreme Court had granted bail. His mother was very pleased for him and she was trying to ensure that he would see or speak to a psychologist that had been arranged by his family. Again, it was a warm and caring phone call. His mother was clearly so relieved and looking forward to his release. In this call he mentioned the observation cell and called it a "punishment cell".

104. This evidence although very painful for the family and friends of JS to hear was very important at inquest. It was a contemporaneous account of how he appeared around the time of the cable tie incident and indeed his death. Although he was teary in both calls, there was nothing said that could have alerted his family or indeed anyone that he was having thoughts other than to get himself out of the prison system and back home.

Evidence of SCO Williams

105. SCO Williams provided a statement and gave oral evidence. He had been a correctional officer for 37 years. The last 20 years he had been stationed in transport, that is, his role was to transfer inmates from gaol to gaol, gaol to courts and into centres. He had worked in reception in prisons in 1999. Between 1999 and 2020, he had not worked in a reception for any gaol. At this time in April, it was the beginning of the pandemic; prisons were understaffed and under pressure, transport was obviously much reduced, and he was redeployed from transport for about 3 months. In that time, he performed many different roles within the centre.

106. SCO Williams was not given much in the way of training and an existing officer told him what he should do. He had some limited recollection of JS. He said that he recalls JS as being quite timid. He agreed that it was his decision to determine placement in the cells. He was advised not to have regard to the Justice Health form, because it was more than 2-4 weeks old. I accepted he had that specific recollection. However, the information he was given was incorrect. He was required to have regard to the Justice Health determination, and in most cases that should be followed unless other matters overtake the assessment.

107. SCO Williams did not fill out the intake form correctly. This was in keeping with the fact that he was given little or no proper instruction to perform the role. I accept that this was an unusual time of COVID and officers were being used in areas that they were not

familiar with. He had not performed the role for over 20 years, and he only filled in that position in reception 2 or 3 times in the time he was deployed there.

108. I accept the evidence of Mr Taylor that this is not usual. He said in evidence that he would expect a senior officer to properly inform themselves prior to undertaking a new role, through use of policy and procedures. I cannot find that there was a systemic error made in this case, but rather in unusual times it was an individual error which saw JS being placed in a one out cell, instead of the group cell as directed by Justice Health.

Registered Nurse Smithers

109. RN Smithers had a good recollection of what occurred on 3 May 2020 involving JS. She was working with RN Fuller at the clinic when they were called to an emergency. The radio indicated that "someone was going blue" so they took the emergency trolley believing someone could not breathe. It was memorable as an event because it was unusual. JS was hysterical and crying, very concerned about being unable to get a cable tie off his finger, he had attached it and pulled it too tight. Nurse Fuller reassured him and was able to remove the tie. When JS calmed down, he said that he did not mean it and that it was an accident. The nurses decided to take him to the clinic. During evidence, RN Smithers explained that she thought it was best to take JS there to increase monitoring.

110. She also recalled that they discussed whether a RIT was necessary, but decided that this conduct did not warrant taking that further step. She explained the RIT would subject him to the possibility of close watch, close monitoring, removal of his clothes and the wearing a safety gown. She did not believe that he needed that. She believed that placing him the clinic overnight would allow for some monitoring.

111. I accept that RN Smithers had JS' best interests at heart. She was being cautious, finding the situation unusual, and warranting attention, however she did not feel that it would be right or helpful for JS to rise to the level of a RIT and the necessary intensive intervention that would involve.

112. There must be a scale of seriousness of an event, and it was a clinical decision at the time by the nurses present to decide that JS required some intervention, but not

escalating it to a higher level. They were also persuaded by him that it was an accident, but nonetheless took precautions.

113. She did not go through his case notes, nor was she aware of the self referrals he had sought for mental health. RN Smithers explained that she was persuaded in part by his evident high level of distress at hurting himself, that she believed the risk of him self-harming to be unlikely.

Registered Nurse Fuller

114. RN Fuller was involved in the cable tie incident. She explained that JS later told her that he was so nervous about the bail hearing the following day. He did seem to calm down significantly upon the cable being removed. JS explained that he was nervously playing with the cable tie and accidently pulled it too tight. She considered his explanation was reasonable in those circumstances.

115. RN Fuller's evidence differed from Nurse Smithers. She was not concerned about his mental health, and believed that they took him to the clinic because he had been very loud and hysterical, and she was concerned that other inmates would harass him if he was to stay in the POD that night. She did not recall specifically but believed that they would have discussed a RIT but decided it was most likely accidental, making it unnecessary to progress him to a RIT. She also noted that he would be assessed the next day by a nurse.

Registered Nurse Cobeanou

116. RN Cobeanou reviewed JS in the clinic the following day. She was made aware that he had obtained bail.

117. JS was adamant that he wanted to return to his cell to say goodbye to his friends. He went to the cell door slumped forward and spoke to her while looking at the floor. She decided that the way he presented himself did not match what he was saying. His mood was low and he didn't present as someone who had just been granted bail would be expected to act. Inconsistent with expectation, he presented with lack of eye contact, slumped and he was teary. RN Cobeanou was concerned and thought he should remain in the cell until he was released.

118. As a result of his presentation not matching what he was saying, RN Cobeanou told JS that he needed to remain there. She felt he may have been at risk, although was unsure what action he might take. RN Cobeanou recalled that she made a note of it and mentioned it during handover. He denied thoughts of self-harm, but she was uneasy about his presentation. She believed that JS accepted her decision and she spoke to him telling him to advise staff if he was not well. He said that he understood. They discussed the buzzer availability and that he should use it if he required assistance.

119. RN Cobeanou also spoke of the pressure to move people out of the clinic and back to the cells. It was clear from her evidence that the clinic is an extremely busy place, with constant pressure to make room for new inmates. Despite this, and to her credit, she determined that JS should stay. It should be noted that JS was in the unusual position of soon to be going home, so it would have been an unusual decision to place him on a RIT. RN Cobeanou acted to keep him safe.

Registered Nurse Crole

120. RN Crole did not specifically recall but the notes showed that she had admitted JS to the Centre on 9 April. She gave evidence that when inmates are transferred by another gaol, Justice Health nurses would review medical records and undertake a brief review of the available notes. Sometimes 30 inmates might come in on one transport. She gave evidence that this was a very brief meeting as a general practice. It is an opportunity to make sure that the inmates are well after transport, and a is chance for any existing medications to be worked out. She said usually inmates are tired and just want to get settled into the new environment.

121. RN Crole was on duty in the clinic on 5 May. She also gave evidence of the pressure in the clinic and that there is usual practice of trying to keep one or two cells clear for the unknown and sudden presentations.

122. RN Crole's description of the clinic painted a busy and fluid working environment. She said that on that day there was a lot of pressure being put on her to move people out of the clinic. She was asked on several occasions by the correctional officer in charge, CO Wettig, whether she had seen JS for an assessment, and indicated that she ought to see him because he was going home on bail that day, and therefore could leave the clinic. She

described being asked again and again “have you done it yet”. Her account was that on top of an already heavy workload this was a significant pressure, interfering with what she was trying to get done, rushing her, increasing the already high stress levels in her workday.

123. CO Wettig told RN Crole that JS was fine, that she had spoken to him, and that he wanted the opportunity to pack his belongings and say his farewell to other inmates.

124. It was a matter of significant regret by RN Crole that she strayed from her usual practice by agreeing to release JS without personally reviewing him. During her evidence, RN Crole stated that she would always review a patient herself, however she was feeling considerable pressure that day and so instead accepted the observations made by CO Wettig. She recalled that he had previously been involved in the cable tie incident. She decided it would be a good gesture to allow him to go and pack his room up and she was also confident because he was going home on bail. She believed that he was in the clinic because of his thumb. RN Crole also had an expectation that he would go to a group cell, given that was his placement indication.

125. RN Crole was deeply affected by this incident. Her evidence supports a finding that she was trying to do the right thing for JS, that she was under significant pressure that day and ordinarily would have reviewed his notes and visited with him before making that decision.

Correctional Officer Wettig

126. CO Wettig had no recollection of that day, however she agreed with RN Crole that there is always a lot of pressure to move people out of the clinic. She described that her role as the clinic officer required her to manage the detoxifying inmates, the suicide watch inmates, RIT inmates, and inmates coming and going to optometrist, dentist and doctor appointments. CO Wettig also provided evidence that the clinic can become a general holding ground to address issues such as isolating members of different gangs. Alongside these tasks, she was also required to assist with providing meals in the clinic, hence her role was constantly moving.

127. CO Wettig stated that there is pressure on Shortland Correctional Centre, particularly as it is a remand centre, meaning that room has to be made in the gaol to accommodate for those coming from court cell facilities and police cells. For that reason, CO Wettig was also tasked to see if she could move inmates out to make room for someone who might need the cell urgently. In doing so, she would ask nursing staff to review inmates in order to assess whether the person really needed to remain, or if they could be released back to the POD.

128. CO Wettig was also concerned by the environment in the clinic. She noted that while inmates were in the clinic, they could not access things such as exercise, sunlight, and phone calls. Therefore, her account was that there is an advantage to the inmate to release them back to their cell if there is not an obvious need for them to remain in the clinic.

129. CO Wettig agreed that she would have regularly asked the nurse whether she could remove JS, as that was consistent with her general practice at the time.

<u>Ms Joyce, Psychologist</u>

130. The evidence was that Ms Joyce was the psychologist who saw JS the day he passed away. Ms Joyce recalls that after reviewing the triage list, she noticed that JS should have already been seen by that stage, as he was overdue according to his categorisation.

131. Ms Joyce was not privy to the Justice Health notes, given that she was part of, and employed by Corrective Services. Her evidence was that JS presented with no concerns. He wanted to get out of the clinic and he was concerned that the cable tie incident was being seen as an act of intentional self-harm, which he denied. He expressed the desire to go back to the POD, and said he was looking forward to going home and being with his parents. He wanted fresh air, and he wanted to make some necessary phone calls.

132. Ms Joyce formed the view that JS was truthful in his indications that he had no intention to self-harm. Ms Joyce was of the view that the granting of bail was a protective factor.

<u>Correctional Officer Farrell</u>

133. CO Farrell had a memory of JS. He said that he went in to see JS with SCO Van Montford. They asked JS to stand at the back of the cell, and then he was directed to sit on the bed as is usual practice. SCO Van Montford went to have a talk with JS and sat down on the stool on the other side of the room. He explained to JS that he had been granted bail, however his parents needed access to his vals bag (anything of value) which required a signature to grant them access. He recalls that JS was emotional.

134. At one point JS got very upset, and stood up expressing concern that he was not getting released. CO Farrell indicated that he needed to sit down or he would need to use chemical spray. At that point JS did calm down, and it was explained to him that he would be released once the procedures had been completed and his parents could ensure the conditions of bail would be met.

135. After this CO Farrell did not hold any concerns for JS' welfare. He was distressed to later hear what happened to JS.

Ms Cuthbertson

136. Ms Cuthbertson was able to give an overview of the processes that are followed in relation to self-referral forms. A Nurse reviews self-referral forms, and determines what type of appointment is needed and what priority they need to be given. Another way to access health services is when inmates attend the clinic in emergency situations. Generally, for non-emergency issues inmates will go on a waitlist for a speciality service. Many referrals are made at the reception process, and there is a significant competition for the use of resources. The many Category 1 inmates require and in fact consume many of the available resources, and the urgency will often override and cause delay to the other levels.

137. JS did not access a doctor for his mental health during his time in custody. The moving of inmates does have an impact on the inmate accessing doctors. At that time there was also vacancy at Shortland for a mental health nursing position.

138. Ms Cuthbertson gave evidence about the newer model of telephone self-referral. This allows an inmate to call and speak to a nurse about their concerns. If the issue is related to mental health, they can be directed to a mental health nurse. This allows better triage

and better understanding of the needs of the inmate. It also allows the system to move from written self-referrals, addressing literacy concerns, language barriers and confidentiality.

139. Ms Cuthbertson indicated that she was keen to support opportunities to improve mental health waiting lists, and that it appears that funding is the limitation preventing change. There is a need for more clinicians, more focus on mental health services, and a broadening of the use of tele-health. One of the requirements in relation to nursing staff appointments is the requirement of post graduate study, often preventing good applicants from taking on the roles.

140. Justice Health would also benefit from having its own psychologists working under the Justice Health umbrella, therefore working in the health space as opposed to corrective services.

141. Funding seemed to be the major concern preventing the provision of services to comply with the current policy timeframes.

Mr Taylor

142. Mr Taylor attended with an impressive background in corrective services, being the General Manager, Corrective Services, and previous Governor of Goulburn Correctional Centre.

143. He gave evidence, and I accept that the use of the HPNF is broadly known and understood. Training is provided on the issue, and the system of reflecting the content of the HPFN when determining cell placement is usual practice. In this case, there was a diversion from usual practice, but he puts that down to individual officer error, as opposed to a broader systemic error.

144. Mr Taylor raised the issue of the roll out of tablets, which can then be more readily used by inmates, connecting them to services where needed. This initiative using technology is a method of assisting potentially the wellbeing of inmates.

145. I accept that the suggestion of eliminating plastic bags from correctional centres is not feasible. They have a very wide range of uses, including sanitation and hygiene.

Mr Shehan

146. Mr Shehan provided very significant and helpful evidence to the inquest. He has considerable experience working within the prison system. He opined that psychological care in prison is generally not adequate. The community has similar shortcomings, and in his experience, it is not unusual to have no choice but to prioritise. More funding for the gaol system and justice health, is needed.

147. He was not critical of the care given to JS. He found that given the limited resources available, staff were doing their very best to treat him, but were unable to get to him the care he needed given the shortage of services.

148. Mr Shehan was of the view that JS ought to have been seen prior to his release from the clinic, however, he also recognised the stress and pressure of working in the clinic environment.

Overview of evidence

149. The tragedy of this death for his family is the timing, they were making arrangements to collect their son, when given the news of his sudden death. All who gave evidence were shocked at the outcome, it was not anticipated by any witness. The grant of bail was thought to be a significant protective factor.

Was adequate mental health support provided to JS by the Justice Health and Forensic Mental Health Network? In particular:

- ***a. The frequency of review by Justice Health staff, in light of JS' reported symptoms,***
- ***b. The reasons why JS was not seen by a psychiatrist prior to his death, and***
- ***c. The reason why JS was not prescribed medication for anxiety.***

150. The matter of concern is that JS did reach out and he did go through the proper process to gain access to a doctor who may have been able to prescribe him some medication to assist him.

151. JS asked for medication and referred himself. He reported that he was not coping, and was reviewed on 16th March by RN Stone. She saw JS after an officer reviewed him.

The evidence shows that he expressed he was stressed but that he was focused on medication, he wanted Valium and knew that he would not get that. She appropriately determined to wait list him semi urgent level 2 to see a psychiatrist within 3-15 days. However, JS waited in excess of 50 days.

152. Evidence was given that he was unlikely to be prescribed the medication that he sought. That is not the issue. A medical doctor or psychiatrist has a significant role to play in mental health because they have the capacity to prescribe, they have the expertise to work out what medications might assist and talk to a patient about those options. JS was not afforded that opportunity.

153. The system failed to comply with its own policy timeframes. It seems unacceptable that a policy exists for the seeing of other category patients when it seems clear that each relevant witness in this case knows those timeframes are not being achieved.

154. An inmate is not being treated as he or she would be in the community. An inmate has no ability to access a medical practitioner, and as in JS' case, there would have been opportunity well within the 50 days that he waited to access a medical doctor.

155. Further, it is concerning that given the better understanding of mental health, there appears to be a distinction being drawn between immediate physical illness as opposed to immediate mental health illness.

156. It is also a lost opportunity in the custodial setting, particularly when an inmate seeks mental health treatment. Although not applicable to JS who was on remand, it is a loss to the very principles of sentencing, that being opportunity to improve chances of rehabilitation and importantly address recidivism. It assists the inmate and the community to have mental health concerns addressed.

157. As Mr Shehan indicated, there is a much larger percentage of the prison population with mental health issues. It seems extraordinary in the interests of the community that the mental health service doesn't even meet the general community standards.

158. There are several simple facts in this case that summarise the disappointing lack of attention given to mental health. JS used the proper process, applied to seek help regarding medication for his mental health on numerous occasions. In breach of the

policy, he was not provided that care within the timeframe of his category. He waited over 50 days for treatment and on the day due for release he took his own life.

159. This matter highlights the attention that mental health should be given. I also note that the system also failed the Justice Health staff and the Corrective Services officers. Work health and safety and issues of distress to the staff who treated JS and located JS after his death should also be of concern. It was clear from the calibre of the staff from both services that they were compassionate and caring, and did the best they could with the limited services available.

Was JS' death intentionally self-inflicted?

160. I am satisfied that JS' death was intentionally self-inflicted. I base that finding on a number of factors present in the evidence. Those include the method he used, including the bag, the ligature, the context itself was an indication that he intended to seriously harm himself, the timing given he was unlikely to be discovered and unlikely to be interrupted, crime scene information and the evidence of other ligatures present. These all speak to intention. Finally, the note he left disclosed his intentions, the stressor of charges and the alleged admission that he had made which troubled him. He also had a background of difficulty coping in gaol and a possible mental health diagnosis.

Was adequate psychological support provided to JS by Corrective Services NSW?

161. His access to a psychologist was adequate. Ms Joyce was a careful and caring practitioner, who did her best to assist JS. He did not disclose his intentions to her. He had a previous assessment which was documented carefully.

Why was JS placed in a single cell after his transfer to Shortland Correctional Centre, and was this in compliance with the relevant policy?

162. It is not known why he was initially recommended for a group cell placement, although it appears it may have been for a physical concern rather than mental health. SCO Williams did not appropriately place JS in accordance with usual practice. It was drawn to my attention that the wording of the policy is not clear on that point, and I would agree with those submissions. Even if SCO Williams had referred to the policy, the wording is ambiguous, and does not make it mandatory on its face to follow the HPNF.

Should a Mandatory Notification have been made after the incident on 3 May 2020?

163. I am satisfied that the nurses caring for JS took appropriate steps to ensure he was properly cared for. After the cable tie incident, RN Smithers said that she and RN Fuller discussed whether JS needed to be on a RIT and they agreed that he did not. They turned their minds to the question. There were warning bells that they did not ignore, they took him to the clinic as a precaution, but afforded him the dignity they could in accepting his claim that he would not self-harm, and by not escalating it to the level of care a RIT would have required.

164. RN Cobeanou did not take JS' word for it, was concerned about him and kept him in the clinic.

165. The policy itself requires that staff use the least restrictive course of action, whereas placing him on a RIT might have resulted in clothes taken, different surroundings, limited belongings. JS himself called it a punishment cell on the phone call to his mum.

166. I accept that the nurses made appropriate decisions to keep him in the clinic, however that after turning their minds variously to the question of mandatory notification they had formed a clinic view that such a step was not required.

Was the decision to release JS from the clinic to a single cell on 5 May 2020 appropriate and in accordance with policy? What alternatives were available?

167. RN Crole made an error, and expressed regret. She gave frank and heartfelt evidence that she would not normally have followed the process she did. She impressed as being overborne by pressure, and took advice from a correctional officer that he was about to be released, and did not follow her usual practice of reviewing notes and interviewing the inmate. However, the Officer had spoken with him and clearly expressed to her that he was doing well and wanted to leave. On that day he also said the same to his mother, and the psychologist. No-one else, including the officers who were last to see him had concerns for his mental health on that day.

168. There is no evidence to suggest that had RN Crole spoken to JS on that day that she would have formed a view different to those who did speak with him.

169. The circumstances of that day should also be taken into account when addressing this issue. It was the case that he needed to return to pack up his cell and it was anticipated that he would be soon released. Even if the flagging of the incorrect cell placement had been identified, it would not be consistent with the evidence that any change of his cell placement would have occurred at that late stage.

Does the method of JS' death reveal a safety risk? How is such risk addressed by Corrective Services NSW?

170. Finally, I accept that the removal of plastic bags from correctional facilities would be a disproportional response, particularly given the important role the plastic bag plays in the facilities for both inmates and staff.

Acknowledgements

To each of the representatives for their assistance at the inquest.

To the family and friends of JS for the family statement that brought a much richer and better understanding of the person who was JS.

To the team assisting, Mr Harris for a thorough and careful presentation of the inquest, drawing out the relevant issues and taking the witnesses through the important parts of the evidence.

Recommendations

After hearing the matter, I helpfully received the following information:

1. CSNSW are currently reviewing its policies and procedures in relation to when an inmate is received at a correctional centre and an accommodation decision is required. A key priority for CSNSW is ensuring the accommodation decision is recorded.

2. COPP section 5.2 *Inmate accommodation* requires the accommodation decision to be made by the Functional Manager (**FM**) or Officer in Charge (**OIC**) of reception. However, it has been identified that there is no requirement under COPP section 5.2 for that officer to sign off on that accommodation decision. CSNSW has drafted amendments to both forms which requires the FM or OIC to sign off on the accommodation decision that they have made. This will also be reflected in COPP section 5.2 as a requirement.

3. CSNSW are considering including a final accommodation decision to take place after the reception procedures are completed (including the Justice Health screening, interview with a Service and Programs Officer (**SAPO**), and the checking officers assessment). This proposed change will be included at the end of both forms for all receptions.

4. CSNSW intend to consult with Justice Health regarding the requirement for signature from the wing officer. This copy of the HPNF is not currently required to be stored on the case management file, CSNSW will propose instead that the custodial officer who initially receives the HPNF from Justice Health signs:
    a. they have received the HPNF; and
    b. they have provided this HPNF to the accommodation area where the inmate is held.

5. In addition, CSNSW has drafted changes for consultation which include a specific list of documents which need to be considered when making an accommodation decision (e.g. HPNF, OIMS, case notes, disciplinary reports).

Noting the work that is being done in this area and the changes that are being considered, there are no additional recommendations that now arise from the death of JS.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

JS

Date of death

5 May 2020

Place of death

Shortland Correctional Centre, Cessnock, New South Wales

Cause of death

Plastic Bag Asphyxia

Manner of death

Intentionally self-inflicted (in a custodial setting)

I extend my sincere condolences to the family and friends of JS. This was a shocking and sudden loss to those anticipating his return home.

I now close this inquest.