CORONER'S COURT

OF NEW SOUTH WALES

Inquest: Inquest into the death of Matthew Grieve

Hearing dates: 19,20 June 2023

Date of findings: 15 August 2023

Place of findings: Coroner's Court of New South Wales

Findings of: Magistrate David O'Neil, Deputy State Coroner

Catchwords: CORONIAL LAW – death in custody, hanging, health problem notification forms, custodial mental health pathways

File number: 2019/324097

Representation: Coronial Advocate: Ms Amanda Chytra
Commissioner of Corrective Services NSW: Ms Skye McKinnon
Justice Health Forensic Mental Health Network and Registered Nurse Brooks: Mr Jake Harris of counsel instructed by Ms Anne-Marie Pascoli of Makison D'Apice
Registered Nurses Goodman and Brolly: Ms Laura Toose

Findings:

Identity:	The person who died is Matthew Grieve
Date:	14 October 2019
Place:	Cell 163, Wellington Correctional Centre NSW
Cause:	Neck compression
Manner:	Self-inflicted hanging

Non-publication order: A Non-publication order pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) has been made in this inquest. A copy of the order can be found on the registry file.

Introduction

1 Mr Matthew Grieve (Matthew) entered custody for the first time in his life on the 6th of April 2019. Matthew died at the Wellington Correctional Centre a little over six months later, on 14 October 2019. Matthew had been in a cell with another inmate up until shortly before his death. Matthew had stopped taking his prescribed medication from the 6th of October. The medication was for his anxiety, depression and panic disorder. On the 14th of October Matthew hung himself whilst alone in his cell having been unmedicated for eight days.

2 Because Matthew died while in custody, an inquest is required by the Coroners Act 2009 NSW (the Act) (s 23).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such

cases the community has an expectation that the death will be properly and independently investigated.

The Coroner's role

4 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act as to:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of the person's death.

6 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding the inquest, a detailed coronial investigation was undertaken. Detective Senior Constable Robert Jackson compiled a brief of evidence that contained correctional centre records, medical records, and statements from staff of Justice Health and St Vincent's Correctional Health. In addition, DSC Jackson spoke with correctional officers and family and friends of Matthew. A

report was obtained from a forensic pathologist as to the cause of death. A Senior Investigator from Corrective Services, Mr John Purcell, undertook an investigation and completed a report. Executive statements were taken from the Acting Governor of Wellington Correctional Centre, now Governor Louise Smith, a co-director of Services and Programs for Justice Health, Dr Sarah-Jane Spencer and the Service Director for Custodial Mental Health, Ms Shona Cuthbertson. In addition, the inquest benefited greatly from the oral evidence of Governor Smith, Ms Cuthbertson, the Acting Manager for State Wide Security CSNSW, Mr Micheal Williams, and Dr Matthew Hearps, Deputy Clinical Director Forensic and Long Bay Hospitals, who made himself available to assist at short notice.

8 All the documents and witness statements obtained during the investigation formed part of the brief of evidence which was tendered to the Inquest and became Exhibit 1. All that material and all the oral evidence has been considered in making the findings detailed below.

9 The Commissioner of Corrective Service New South Wales, The Justice Health Forensic and Mental Health Network and Registered Nurses Brooks, Brolly and Goodman were all represented in the Inquest.

Background

10 Born on 13 February 1992 Matthew was only 27 when he died. Matthew had a very difficult upbringing. His biological father passed away when he was a young man. In addition, Matthew was estranged from his mother from an early age. Matthew's mother had four children to four different fathers and was estranged from all the children. Matthew was raised by his grandfather.

11 Matthew and his half-sister were very close, and he had a number of friends to whom he was also close. Matthew's grandfather was the most significant adult figure in his life. It would seem however that Matthew felt that he let down family and friends as he faced his demons throughout his life.

12 In terms of medical history Matthew was diagnosed as suffering from anxiety, depression and panic disorder for which he was medicated. Matthew had self-harmed by way of cutting himself when he was about 22. Matthew saw his troubles as arising from his difficult upbringing.

13 Matthew was arrested by the Australian Federal Police on 4 April 2019 and charged with the offences of importing a marketable quantity of border-controlled drugs and possession of prohibited drugs. He was bail refused by police at Gosford Police Station and transferred to the Surry Hills Court Cells the same day. This was Matthew's first time in custody. Two days later he was taken to Newcastle Local Court and on the same day moved to Shortland Correctional Centre

Mental health assessments and cell placement whilst in custody

14 As part of the usual process when someone enters custody an employee of Justice Health NSW (JH) conducts a Reception Screening Assessment (RSA). One of the purposes of the RSA is to assess the inmate's mental and physical health. The employee who performs the assessment determines whether any more detailed mental health or physical assessment is required and makes a recommendation to Corrective Services NSW (CSNSW) as to the appropriate cell placement for the inmate.

15 As part of the process applicable as at 2019 the JH employee who assessed Matthew was required to complete a health problem notification form (HPNF).

Notations are made on the HPNF as to appropriate cell placement and "symptoms to look for". The policy in relation to HPNFs required, as at 2019, that the JH employee ensure the HPNF was signed, copied, provided in duplicate to CSNSW and then filed. In the Policy it was stated that there was both a duty of care and a statutory duty to complete the form so as to properly inform CSNSW of the inmates actual or potential "at risk" health problems.

16 After Matthew entered custody a RSA was undertaken at Shortland Correctional centre on the 6th of April. Following that assessment, a HPNF was completed. On the HPNF it was indicated that Matthew was to be placed in a "two out" cell and that he should be encouraged to eat and drink. On the form there was indicated an 'until date' of 20 April 2019. The Registered Nurse who completed the form signed it. A CSNSW receiving custodial officer also signed it.

17 If an inmate has physical health issues, mental health issues or is in custody for the first time it is thought to be preferable that they be in a cell with another inmate. This is referred to as "two out". The presence of the other cellmate is seen as a protective measure in that the cellmate can alert the CSNSW officers if he observes signs of any health issues.

18 In addition to the HPNF there was an entry for the 6 April 2019 in Matthew's "progress/clinical notes" maintained by Justice Health. The same registered nurse made the notes as completed the HPNF. Within the clinical notes it is recorded that Matthew stated he had self-harmed in the past but had no current thoughts of suicide or self-harm. The registered nurse indicated a plan, which included two out cell placement, and placing Matthew on the waitlist for a welfare check and mental health triage.

19 The RSA conducted on 6 April 2019 was properly completed and all necessary paperwork was signed and placed in the appropriate files.

20 On 10 April Matthew's GP provided information to JH that indicated Matthew was prescribed medication for anxiety, depression and panic disorder. In

addition, the information indicated that Matthew was prescribed the antipsychotic medication Seroquel (quetiapine) “off-label”. Off-label prescription means the medication was not prescribed for the primary or usual purpose for which that medication is authorised. In evidence Dr Hearps suggested that the relatively low dosage of quetiapine Matthew was prescribed to address his anxiety and help him sleep and was not for psychosis. I accept that the quetiapine was not for psychosis.

21 During his CSNSW investigation, Senior Investigator John Purcell located an unsigned HPNF dated 19 April 2019 in the Corrective Services file relating to Matthew. He did not locate any reference to this document in the JH records. In the documents produced to the inquest by Justice Health, similarly, there was no 19 April 2019 HPNF. As shall be developed below the evidence did not explain why CSNSW had a filed 19 April HPNF and JH did not.

22 The HPNF dated 19 April was not signed by anyone from either JH or CSNSW. The only typed entries on the document indicated “nil acute issues” and “normal cell placement” as well as the name, Maeve Brooks. Additionally, as noted, it was not placed in the JH health record. No JH progress/clinical notes were made in relation to Matthew for 19 April.

23 The nurse whose name is recorded on the 19 April HPNF, RN Maeve Brooks, gave evidence that she had no recollection of any interaction with Matthew. She indicated that it was her invariable practice to sign the HPNF, make sure a custodial officer signed the original, provide two copies to CSNSW and place the original in the health file. Upon questioning she gave evidence that at times there were staff shortages at Shortland Correctional Centre in that there was one nurse less than the required number plus no visiting GP was available or there was no mental health nurse available. RN Brooks indicated that these staff shortages impacted on all staff at times. She also gave evidence that others could access the JH electronic system using her identification details and that loose-leaf clinical notes were placed into stackable draws and would sometimes go missing.

24 One of the documents produced by JH was the Patient Administration System printout relating to Matthew. That printout became Exhibit 2 in the inquest. The printout includes three entries under RN Brook's user identification number relating to Matthew on 19 April 2019. These entries refer to the creation of a "clinical document" and the removal of Matthew's name from the waitlist on which he had been placed on the 6th of April. The "clinical document" entry was made at 11:28. The time noted on the unsigned HPNF is also11.28.

25 I found RN Brooks to be an honest witness. I believe that she had no independent recollection of any interaction with Matthew. I believe that she finds it hard to accept that she would not have signed a HPNF she had created. I also accept that others could enter information under her identification number.

26 Whilst it is not possible to determine exactly what occurred on 19 April, I consider it more likely than not that RN Brooks saw Matthew on that day and created a HPNF.

27 The lack of a signature, on the HPNF, lack of any clinical note and the absence of the HPNF in the JH file all suggest that something happened to interrupt the process that was being undertaken in relation to Matthew on 19 April or that the process was done hurriedly. That is not a criticism of RN Brooks, as there may have been external factors, such as staffing levels that caused the process to be interrupted or hurried.

28 There were a number of failings in relation to the HPNF dated the 19th of April. A JH employee or employees failed to meet their responsibility to ensure the HPNF was signed, copied, provided in duplicate to CSNSW and then filed. In addition, CSNSW staff should have realised that they had been provided with a HPNF that had not been signed by a JH employee. This should have immediately been taken up with the nurse unit manager (NUM) or delegate or the person whose name was on the form. The HPNF was an incomplete form and given its importance it should not have been treated as if it was acceptable.

29 The likelihood that the assessment of Matthew on 19 April was either interrupted or done hurriedly raises significant concern as to the level and extent of the assessment that was undertaken on that day particularly in the circumstances where Matthew's entries on the waitlist for a welfare check and mental health triage were cancelled and his cell placement recommendation changed.

30 As at 19 April there were in existence two HPNFs. As the 19 April form was incomplete it should not have been treated as the current and applicable form. The 6 April form had an "until date" of 20 April. Neither form was appropriate to accept after 20 April.

31 Subsequent to the 19th of April numerous opportunities were missed by both CSNSW and JH to identify that the 19 April HPNF was incomplete and or that the applicability of the 6 April HPNF had ended.

32 Each time an inmate is moved from one correctional centre to another there must be a JH assessment of the inmate at the new centre. As part of that assessment there must be an appropriate HPNF on file. In addition the HPNF needs to be checked by the CSNSW OIC of reception in the new centre and then by the wing OIC when the inmate goes to a wing. A copy of the HPNF travels to the wing in which the inmate is housed.

33 Despite these requirements no one from CSNSW took any action in relation to the incomplete HPNF at either Parklea or Wellington. Matthew was moved to Parklea on 10 June and then to Wellington on 12 July. Neither of the CSNSW checklists completed on 10 June or 12 July indicated (as they were required to) whether the HPNF in the file had been reviewed. In the Wellington check list there was no indication at all as to what the "accommodation decision" was for Matthew.

34 Similarly each time Matthew was moved JH employees in the reception section of the new correctional centre had the opportunity to establish either that the 6 April HPNF had long passed its "until date" (assuming the 19 April HPNF was

not in the JH file) or if the 19 April HPNF was “visible” observe that it was unsigned. Either way a new HPNF should have been completed following an appropriate assessment.

35 It is very difficult to understand how it came to be that not one employee from JH or CSNSW raised issue about there not being an appropriate HPNF on file. It suggests that those involved, as a collective, didn’t understand the true importance of the HPNF, didn’t care sufficiently about the content of the HPNF or were impacted upon by external matters such as understaffing or being overworked. There was evidence that reception areas of correctional centres can be extremely busy from time to time. Somewhat disturbingly Mr Micheal Williams, the Acting Manager for State Wide Security CSNSW gave evidence that in his experience the HPNFs are often not signed.

36 It his worth emphasising that the JH responsibility to advise CSNSW as to an appropriate cell placement arises from both a general duty of care and a statutory duty. Appropriate cell placement is an extremely important decision in relation to the wellbeing and health of each and every inmate.

37 Clearly there is a need for steps to be taken to minimise the risk of HPNFs not being appropriately completed and checked as to their applicability. Acting Governor Smith suggested that audits, including spot audits might be an appropriate approach. Mr Williams agreed that this could be helpful. Mr Williams also gave evidence that there is currently a full review of how cell placement decisions are made, when they must be undertaken and by whom, particularly when an inmate is received at a Correctional Centre. This will necessarily include focus upon HPNFs and is likely to require some input from JH.

38 As a result of no new HPNF being created after the 19th of April, CSNSW continued treating Matthew as suitable for “normal cell placement”. This situation continued in circumstances where it is likely the assessment on 19 April was less than optimal and Matthew did not at any stage during his time in custody have a welfare check or mental health triage. Given that Matthew was

medicated for anxiety, depression and panic disorder, was in custody for the first time and had previously "cut" himself it is less than satisfactory that this remained the situation when it is not possible to have any confidence that the JH employees who saw Matthew on 19 April, 10 May and 12 July undertook their tasks with appropriate attention to detail.

39 It is not possible to know what cell placement would have been recommended, what Matthew's medications would have been and whether any other steps would have been taken in relation to Matthew's welfare and mental health if he had ever undergone the welfare check and mental health triage for which he was booked in when first seen on the 6th of April. Ms Shona Cuthbertson, the JH Service Director for Custodial Mental Health gave evidence that a new Mental Health Care Pathways Framework (Framework) is being developed by JH. Under the Framework when Matthew first entered custody, he would have been referred by the reception nurse to a mental health nurse for triage and determination of an appropriate pathway. This step would have been documented. The initial HPNF would not be time limited and would remain applicable until a new HPNF was put in place. The Framework aims to improve documentation, standardise procedures and ensure screening and assessment processes are empirically informed so as to reliably direct the inmates' care.

Events leading up to Matthew's death

40 Whilst Matthew was at Wellington, from 12 July 2019, he was in a two out cell until his cellmate moved out on 12 October.

41 As with other inmates Matthew was able to attend JH staff each day to pick up his prescribed medications.

42 On 8 October 2019 enrolled nurse (EN) Goodman noticed that Matthew did not attend to take his medication and that he had not attended for the two days prior.

43 EN Goodman saw Matthew at his cell door on 9 October. EN Goodman, who was not trained as a mental health nurse, upon talking to Matthew thought that he did not seem irrational or agitated and overall seemed "quite good''. Despite this assessment EN Goodman sensibly and responsibly retained some concern that Matthew was not taking his medication and in particular the antipsychotic medication. Upon discussing the matter with a mental health nurse EN Goodman placed Matthew on a GP waitlist. This was based on her view that Matthew was a "level A" patient under the policy guidelines that were in place.

44 It was accepted during the inquest that the guidelines in place at the time were unclear as to whether an inmate was level A or level B. Due to this lack of clarity rather than an error by EN Goodman or the mental health nurse, the assessment of Matthew's level was incorrect.

45 EN Goodman emailed the mental health consultation liaison nurse, RN Brolly on the 13th of October following a conversation about Matthew with a psychiatrist.

46 The classification error in relation to Matthew was picked up on 14 October by RN Brolly who clarified for EN Goodman that Matthew's proper classification was "level B" and that Matthew should have been referred to a mental health nurse waitlist rather than a GP waitlist. It is not possible to conclude that correct classification of Matthew and placing him on the correct waitlist would have resulted in him seeing a mental health nurse or a psychiatrist prior to 14 October. Indeed, on the evidence, it is more likely than not that even with correct classification Matthew would not have been seen prior to his death.

47 When an inmate decides not to take prescribed medication both JH and CSNSW employees are limited in what they can do. As is the case in the community no individual can be forced to take medication. So far as corrective

service offices are concerned, they can keep the inmate under observation and look for indicators of behaviour suggestive of poor mental health. JH employees can make efforts to speak with an inmate who is not attending to pick up his medication when those JH employees are attending upon other inmates to deliver medication or by having the inmate called (over the loudspeaker system) to attend upon the nurses who are distributing the medication “at the window”. Beyond those steps an appointment can be made for the inmate to see a clinical professional but once again the inmate cannot be compelled to attend upon that professional if they choose not to.

48 EN Goodman gave evidence that she had been taught to wait three days, when an inmate stopped taking medication, then attempt to have the inmate come to the window and if that did not work refer the inmate to either a GP or mental health assessment.

49 It was accepted by JH that the Custodial Mental Health Referral and Case Management Policy and the Primary Care Guidelines for the Management of Clinical Level A patients with Mental Disorders did not provide clear guidance for inmates in Matthew’s position of being apparently stable but prescribed an off-label psychotropic medication. The Framework, currently being developed, will replace these Guidelines. Relevantly it aims to provide clarity in relation to patient classification and will replace the Level A and B categories with a new approach.

50 In addition, the Psychotropic Medication Prescribing Guidelines have been amended so as to require a more robust clinical assessment in relation to continuing psychotropic medications that were prescribed in the community. Furthermore off-label Quetiapine is no longer supported in the custodial environment. Under the new Guidelines someone in Matthew’s position would require full review by a medical practitioner to determine an appropriate medication regime.

51 In relation to inmates not taking their medication the JH Medication Guidelines were amended in October 2020 and June 2022. The amendments require that

"all attempts must be made to contact the (patient) inmate as to the reason why they have not collected their medication" and "if medication cannot be administered nursing staff are to contact the medical officer/nurse practitioner for advice". The amendments formalise the approach to be taken and mandate escalation if an inmate is not taking prescribed medication.

52 The further change in Matthew's situation in the lead up to his death was the fact that his cell mate moved out of the cell on the 12th of October. Acting Governor Smith gave evidence that she was unable to locate any record that indicated why Matthew's cellmate moved out. Senior Investigator John Purcell was unable to uncover any reason as to why the cellmate moved during his investigation. Mr Purcell was advised there was no animosity between Matthew and his former cellmate. No evidence was adduced in the inquest to explain why the cellmate moved.

53 The CSNSW officers left Matthew in a cell by himself once his cellmate moved out because they relied upon the incomplete HPHF of 19 April. As set out in detail above, this should not have happened.

54 At about 3.30 pm on the 14th of October 2019 Matthew was locked in his cell for his evening meal. At about 8pm that same night an officer looking for spare mattresses opened the cell door flap to Matthew's cell and saw him on his back with a torn bed sheet around his neck. Matthew was unconscious and was not able to be resuscitated despite a speedy and appropriate medical response. Matthew was declared deceased at 8.29pm. Matthew had connected the end of the bed sheets to one of the footplates that were in place for climbing on to the top bunk.

55 Matthew left a number of handwritten notes in his cell, the content of which confirmed his intention to take his own life.

56 Troy Jurd, Director Infrastructure and capacity planning for CSNSW provided a statement to the inquest in which he confirmed that the cell in which Matthew died has been refurbished and the ligature points removed. Mr Jurd also noted

that the efforts to improve cell safety since 2016 included new cells built with anti-ligature design principles, removing obsolete cells and refurbishing existing cells to remove hanging points.

57 The investigation following Matthew's death confirmed there were no suspicious circumstances.

58 The autopsy report confirmed that Matthew's death was caused by neck compression due to hanging.

Whether any recommendations required pursuant to s82 of the Coroners Act

59 As has been set out above a number of steps have been taken by both JH and CSNSW since Matthew's death.

60 A new Mental Health Care Pathways Framework (Framework) is being developed by JH which will address issues relating to classification of the mental health needs of inmates, meeting these needs in relation to each inmate and also addressing some issues relating to HPNFs.

61 The Psychotropic Medication Prescribing Guidelines have been amended, as have the Medication Guidelines in relation to inmates who are not taking their medication.

62 Both JH and CSNSW provided evidence of their aim to reduce suicides in custody. The Ministry of Health has a Towards Zero Suicides Initiative that seeks to embed a systematic approach to working towards a reduction in suicides in custody. The Initiative is a key focus of JH's strategic plan for 2023-2032. Similarly, reduction of suicides in custody is a key aim of the CSNSW 10-year strategic plan covering the same period. JH and CSNSW are collaborating

on this through a steering committee established by JH which includes a Joint Working Group on Suicide Prevention.

63 It is inescapable that assessment of the mental health needs of inmates and the recording of that information is completely reliant on employees adhering to policies and guidelines. The failures in relation to documentation revealed in this inquest as relating to HPNFs has revealed a need for education as to the importance of the HPNFs combined with audits to check that HPNFs are being completed in accordance with the applicable policies and guidelines. CSNSW has indicated that it is currently undertaking a review of cell placement provisions which will necessarily involve consideration of HPNFs as they are the documents prepared by JH that inform the cell placement decision. It will be necessary for JH to cooperate with or participate in the CSNSW review. It is a matter for those two entities as to how they work together and in making a relevant recommendation I will not seek to recommend how that cooperation takes place. Additionally, once the new cell placement policy or guidelines are put in place it will self-evidently be necessary for all involved JH and CSNSW staff to be educated as to any new approach. I will not enter the domain as to how that education should take place.

64 As part of the review into cell placement, consideration should be given as to the appropriate steps to take in relation to cell placement when an inmate stops taking medication. Senior Investigator Purcell referred to the examples of inmates with a history of suicide attempts or self-harm, inmates with a recorded history of suicide or depression or inmates medicated for those same issues. The tragic coincidence of Mathew stopping his medication, his cell mate moving out and him taking his own life cannot be ignored. There was competing evidence in the inquest as to the practicability of dealing with cell placement each time an inmate stops taking prescribed medication. Nevertheless, Mr Williams accepted that it is a topic that could be considered as part of the review of cell placement policy and guidelines. In my view it is essential that it be given very careful consideration by both JH and CSNSW.

Recommendations

65 As indicated both CSNSW and JH have already taken a number of steps in relation to issues arising from Matthew's passing. The fact that these steps have taken place means that no recommendations are required in relation to those issues. However, for the above reasons the following recommendations were circulated in draft form to the parties.

66 CSNSW and JH supported recommendations 1 and 3, as drafted.

Recommendation One

67 <u>In its ongoing review into cell placement CSNSW consider the implementation of audit processes for Health Problem Notification Forms and further education of its employees so as to ensure that HPNFs that are being relied upon are appropriately completed and current.</u>

Recommendation Two

68 The draft recommendation read as follows:

CSNSW and the Justice Health Forensic and Mental Health Network (as part of the CSNSW's cell placement review, or otherwise) consider appropriate steps to take in relation to cell placement recommendations and ultimate cell placement when an inmate stops taking prescribed medication.

69 CSNSW did not oppose the recommendation being made but did note that it is dependent upon Justice Health advising CSNSW of any relevant change by means of a new HPNF.

70 Justice Health accepted that a patient's decision to stop taking prescribed medication may result in a new clinical presentation and consequently may require a new recommendation as to cell placement in a HPNF.

71 Whilst Justice Health's current HPNF policy requires consideration be given to a new HPNF whenever a patient's clinical condition changes it would still be helpful if the policy specifically drew attention to the need to consider whether a new HPNF is required when a client stops taking prescribed medication. Importantly, any change to the policy can also draw attention to the need to specifically consider the question of cell placement in the context of the patient not taking prescribed medication.

72 The amended recommendation as put forward by Justice Health addresses the relevant issues.

73 Given that the current HPNF policy requires that Justice Health provide each new HPNF to CSNSW the original recommendation can be divided into two. Once a new HPNF is completed it must be forwarded to CSNSW who then will consider the recommendation as to cell placement as well as any other recommendations and comments.

Recommendation 2a is:

74 <u>That the Justice Health Forensic and Mental Health Network consider updating its policy/procedure to require review of a patient's HPNF specifically as it relates to recommendations which may guide CSNSW cell placement decisions, when the patient stops taking prescribed mental health medication for a clinically significant period.</u>

Recommendation 2b is:

75 **CSNSW, as part of its cell placement review, consider appropriate steps to take in relation to cell placement, when provided with a new cell placement recommendation from Justice Health (in a new HPNF) when an inmate stops taking prescribed medication.**

Recommendation Three

76 **The Justice Health and Forensic Mental Health Network consider the implementation of audit processes for HPNFs so as to ensure that they are appropriately completed and current.**

Findings under s81 of the Coroner's Act

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

Identity: The person who died is MATTHEW GRIEVE

Date: 14 October 2019

Place: Cell 163, Wellington Correctional Centre NSW

Cause: Neck Compression

Manner: Self-Inflicted Hanging

Closing

78 I acknowledge and express my gratitude to the Coronial Advocate assisting the Coroner, Ms Amanda Chytra, for her assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Jackson, for his work in the Police and Coronial investigation and compiling the evidence for the inquest.

79 I thank the legal representatives of each person and entity represented in the proceedings.

80 On behalf of the Coroners Court of New South Wales, I offer sincere condolences to the family and friends of Matthew

81 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales