CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Paul Hannan
Hearing dates:	8 February,10 March, 2023
Date of findings:	28 March 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, intentionally self-inflicted
File number:	2020/257581
Representation:	Kai Jiang, Coronial Advocate Assisting Katherine Guilford, for the Justice Health and Forensic Mental Health Network (Justice Health) Anastasia Poulios, for the Commissioner of Corrective Services, NSW Harry Black, for Mr Hannan's family
Findings:	Identity: The person who died is Paul Hannan Date: Paul Hannan died on 3 September 2020 Place: Mr Hannan died in Cell 51 of Darcy unit at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales Cause: Hanging Manner: The manner of Paul Hannan's death was intentionally self-inflicted
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 orders can be found on the registry file.

Introduction

1 Mr Paul Hannan died at the Metropolitan Remand Centre at Silverwater on 3 September 2020.

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

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. It is not the purpose of an inquest to blame or punish anyone for the death. The fact of holding an inquest does not imply that anyone is guilty of wrongdoing.

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, namely;

- 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 an inquest a detailed coronial investigation is undertaken. Investigating Police compile a brief of evidence and a report is obtained from a forensic pathologist as to the cause of death. Given that Mr Hannan's death occurred whilst he was in custody in a correctional facility it was thoroughly investigated by Police, who obtained correctional centre records, including medical records and incident reports as well as medical records from Manning Base Hospital. The Police also interviewed correctional officers and Ms Nicole Banks, with whom Mr Hannan had been in a relationship from 2012.

8 The Coronial investigation also obtained relevant policy documents and received a Serious Incident Report undertaken by a senior investigator from the Corrective Services' Investigation Branch.

9 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered during the Inquest. All that material, and the evidence of Detective Senior Constable Joel Swales, given at inquest, has been considered in making the findings detailed below.

BACKGROUND

10 Mr Hannan was born in Dundee, Scotland, on 3 January 1961. He has four sisters, one stepsister and one stepbrother. Mr Hannan's family lived in New Zealand for some time before moving to Australia after Mr Hannan completed his high school education.

11 Mr Hannan and his ex-wife, Sherrie had three sons, Gerard, Elliot and Tyler. Tyler is the senior next of kin.

12 Mr Hannan's 16-year marriage to Sherrie ended in 1997. In 2012 Mr Hannan met Nicole Banks and commenced living with Ms Banks and her son in the suburb of Cranebrook, New South Wales. They were engaged in 2016.

13 Mr Hannan worked as a labourer and later as a forklift driver however his alcohol dependence made it difficult for him to maintain regular employment.

14 Mr Hannan would drink up to four litres of wine daily. Mr Hannan had attended several drug and alcohol rehabilitation centres to combat his addiction. However, ultimately, he failed to successfully complete any of the rehabilitation programs.

15 In 2019 an apprehended domestic violence order was put in place which prohibited Mr Hannan from being within 100 metres of Ms Banks residence. Mr Hannan moved to Taree, however he and Ms Banks kept in close contact. It seems Mr Hannan drank very heavily during this period, and this led to deteriorating mental health resulting in three admissions to Manning Base Hospital during March and April 2019. The medical reports in relation to those admissions indicate an episode of Mr Hannan repeatedly headbutting a wall, and occasions of alcohol withdrawal accompanied by thoughts of self-harm.

16 In August 2019 Mr Hannan was imprisoned for four months for a breach of the apprehended domestic violence order.

17 Mr Hannan was again imprisoned on 23 February 2020 for a period of nine months and was released to parole on 21 July 2020. Following a further breach of the apprehended domestic violence order Mr Hannan re-entered police custody on 25 August 2020.

EVENTS IN CUSTODY LEADING UP TO 3 SEPTEMBER

18 Mr Hannan went from police custody to Amber Laurel Correctional Centre at Emu Plains. At Amber Laurel Mr Hannan was assessed on 26 August for alcohol withdrawal, observed by nurses, and prescribed Diazepam.

19 On 27 August, whilst Mr Hannan was still at Amber Laurel a Reception Screening Assessment (RSA) was undertaken. The clinical assessment of Mr Hannan was "in alcohol withdrawal". It was noted that Mr Hannan had suffered from alcohol dependence from age 32 and was diagnosed with cirrhosis of the liver in 2019. In relation to Mr Hannan's mental health, an assessment was commenced using the "Kessler 10" questionnaire, however it was unable to be completed. A risk assessment was also undertaken and during that process Mr Hannan indicated he was being treated in the community for depression and that he was being treated with Mirtazapine (an anti-depressant). Following the RSA, the incomplete mental health assessment and the risk assessment a Health Problem Notification Form (HPNF) was completed. The HPNF noted the signs and symptoms others in Justice Health should look out for, in relation to Mr Hannan, as being: "previous custody, MH (mental health) issues, AOD (alcohol and other drug) use". It was also noted that Mr Hannan did not have any thoughts of deliberate self-harm or suicide and that he was in withdrawal and suffered from high blood pressure. There was also a notation "health cat 1".

20 The "health cat 1" notation indicated that the screening nurse was referring Mr Hannan to the custodial mental health services for an assessment to be completed.

21 Shortly after the RSA was undertaken Mr Hannan was transported from Amber Laurel to the Metropolitan Remand Centre at Silverwater.

22 At Silverwater an Inmate Screening Questionnaire was completed on the afternoon of 27 August and it was noted on the HPNF that Mr Hannan was suffering from "AOD use withdrawal, MH issues and high blood pressure".

23 In terms of Mr Hannan's withdrawal from alcohol he was required to be placed in an observation cell. This occurred for only a very short period of time, on 27 August, due to a combination of demand for use of the observation cells and work being conducted on some of the observation cells. Nevertheless, Mr Hannan's placement was not in any way contributory to Mr Hannan's death as he was cleared for "normal cell placement" on 31 August.

24 A mental health assessment was conducted by a mental health nurse on the afternoon of 29 August. That assessment appears to have been, at least to some extent, informally undertaken, as neither of the available assessment forms was completed. At the time the assessing nurse could have completed, either a mental health

triage form or a mental health assessment form. The applicable policy indicated that one of those forms "should" have been completed.

25 The mental health nurse made an e-record (electronic system entry) in which it was noted that Mr Hannan had been suffering from significant social stressors in the community, had been prescribed mirtazapine and was currently exhibiting as anxious and of flattened affect. It was noted that Mr Hannan denied any thoughts of self-harm.

26 Shortly after the mental health nurse's assessment the psychiatry registrar issued a 7-day phone order for Mirtazapine for Mr Hannan. The registrar also noted "review by psychiatrist /MH Nurse, possibly on Monday". Neither the registrar nor the mental health nurse who conducted the assessment provided statements as neither now works with Justice Health. On the information before me, bearing in mind the registrar issued a 7-day order on Saturday August 29 and recommended a review to be "possibly on Monday" I am satisfied it is likely the registrar saw a relatively urgent need for a thorough review of Mr Hannan's mental health. No such review took place. The only mental health review which did take place was that conducted by the mental health nurse without completing either of the available forms.

27 Since Mr Hannan's tragic passing Justice Health has amended its policies so that every patient who is now referred to custodial mental health "must" be assessed by completion of either the triage form or the mental health assessment form.

28 It is clear that whilst Mr Hannan was in custody the primary focus of those involved in his observation and treatment was his withdrawal from alcohol together with covid 19 isolation and testing. He was regularly seen by nurses in relation to these matters and they would regularly ask Mr Hannan how he was feeling. In all discussions with nurses Mr Hannan indicated he felt he could cope with custody due to previous experiences and denied any thoughts of self-harm.

29 Despite these regular observations by nurses, and Mr Hannan's comments, there should have been a mental health assessment of Mr Hannan based on either the triage form or the mental health assessment form.

EVENTS OF 3 SEPTEMBER 2020

30 Between 12:30pm and 4:30pm on Thursday 3 September Mr Hannan was observed throughout the afternoon moving around within cell 51 and frequently looking out of his cell through a window.

31 Mr Hannan's last movements were captured on external CCTV at 5:40pm where his silhouette can be seen moving inside the cell.

32 At 6:14pm on the same day a corrective officer walked past cell 51, however, no observation was made of the inside of the cell. At 6:56pm Justice Health staff and corrective officers attended Mr Hannan's cell as part of their evening medication round.

33 Mr Hannan was observed to be seated at the rear of the cell below the window next to the bed. Corrective officers knocked on the cell door, but Mr Hannan did not respond. A medical response was immediately requested. When corrective officers entered Mr Hannan's cell they observed a twisted bed sheet around Mr Hannan's neck which was tied to the window bars of his cell window above where he was seated.

34 The officers immediately cut the bed sheet, laid Mr Hannan's body flat on the floor and commenced resuscitation.

35 NSW Ambulance were contacted and arrived at 7:12pm, however, despite resuscitation efforts, at 7:34pm on 3 September 2020 Mr Hannan was declared life extinct.

36 An external post-mortem examination was conducted and concluded that the cause of Mr Hannan's death was in keeping with hanging.

37 Nothing was detected in the investigation which suggested Mr Hannan’s death was suspicious.

Whether any recommendations are required pursuant to s 82 of the Coroners Act

38 As indicated above, there was no appropriate mental health assessment of Mr Hannan during his time in custody.

39 It is important that when inmates first enter custody adequate assessments are made.

40 The policies in place at the time of Mr Hannan’s incarceration in August 2020 indicated that the mental health triage form or the mental health assessment form “should” be completed when a patient was referred to custodial mental health.

41 Following Mr Hannan’s death the policies were changed so that, now, upon referral to custodial mental health, either a mental health assessment E-form or a mental health triage E-form “must” be completed. The mandatory requirement to complete what is assessed to be the applicable form is a significant and appropriate change in the relevant policy.

42 Given the changes already made by Justice Health, there is no need for any further recommendations.

FINDINGS

43 For all the above reasons I make the following findings:

Identity: Paul Hannan

Date: 3 September 2020

Place: Cell 51 of Darcy unit, Metropolitan Remand and Reception Centre, Silverwater, NSW

Cause: Hanging

Manner Intentionally self-inflicted

Closing

44 I acknowledge and express my gratitude to the Coronial Advocate assisting, Mr Kai Jiang, for his assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Joel Swales, for his work in the Police and Coronial investigation and compiling the evidence for the inquest.

45 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Mr Hannan.

46 I close this inquest.

Magistrate David O’Neil
Deputy State Coroner
Coroners Court of New South Wales
28 March 2023