CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of SH
Hearing dates: **Place of hearing:**	20, 21,22 June 2023 Singleton Local Court
Date of findings:	16 August 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-death in custody-adequacy of care-knock up records-ability for family or NOK to contact Correctional Centres with welfare concerns of an inmate
File number:	2020/22402
Representation:	Mr D Barrow, Counsel Assisting instructed by Mr L Sampson, Crown Solicitor's Office Ms H Fitzsimmons, NSW Legal Aid, representing the family Ms V Wei, instructed by Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Ms K Hollombe, instructed by Makinson d'Apice Lawyers, representing Justice Health and Forensic Mental Health Network

	Mr S Russell, instructed by McNally Jones Staff Lawyers representing Mr P Lawson
Findings:	I find that SH died on 19 January 2020 at Cessnock Correctional Centre, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.
Non-publication orders:	Orders for non-publication of certain evidence have been made in this inquest. The orders may be found on the Registry file.

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NOTE: PURSUANT TO S 75 OF THE CORONERS ACT 2009 I DIRECT THAT THERE BE NO PUBLICATION OF ANY MATERIAL THAT IDENTIFIES THE DECEASED PERSON OR HIS FAMILY

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the unexpected and sad death of SH who was only 28 years of age when he took his own life while he was in custody at Cessnock Correctional Centre.

2. An inquest into the death of a person in custody is mandatory. The role of a coroner is to make the following findings that are required by s 81(1) of the Coroners Act 2009 (The Act), namely:

   i. the identity of the deceased.
   ii. the date and place of the death; and
   iii. the manner and cause of the death.

3. In a case of this nature the community has an expectation that the death will be carefully and independently investigated and that there will be a detailed account of the circumstances surrounding SH's death.

4. At the conclusion of the inquest the coroner may also make recommendations, arising from the evidence, in relation to matters that might prevent a similar death in the future.

5. Pursuant to section 37 of the Act a summary of the details of this case will be reported to Parliament.

SH

6. SH was born on 7 February 1991 in Western Australia. He was the third eldest child of eight. In 2000 the family moved from Western Australia to the Cessnock area, due to the ill health of his grandmother.

7. SH was a gifted athlete at school. There are some impressive photos of him on the rugby field. He had a passion for football.

8. His brothers describe their times with him hunting, fishing, and camping. He loved being in nature and was a conservationist. They have been left bereft.

9. In late 2009, SH commenced a long-term relationship and between 2012 and 2017 he had four daughters. The girls miss their father every day.

10. His family described him as a big tough man who was calm and affectionate and who lit up a room with his soft kind heart and excited energy. He was the family protector. He has clearly left a large gaping hole, in a large loving family.

Cessnock Correctional Centre

11. On 3 December 2020 SH was arrested on a warrant for a breach of an intensive correctional order and taken into custody and housed at Cessnock Correctional Centre. He remained in custody from that point until his death seven weeks later on 19 January 2020. He had only been in prison once before and that was also for a breach of a similar order. That time he spent five months in custody. He was not accustomed to being in custody.

12. Justice Health and Forensic Mental Health Network (JH) and Corrective Services NSW (CSNSW) assessed his mental health and risk of harm status at intake. He was assessed to have no risk of harm concerns and was cleared for "Normal Cell Placement", meaning that he could be housed as either "one out" (a cell on his own) or "two out" (sharing a cell with one other inmate).

13. During the period in custody prior to his death, SH was very concerned about the status of his relationship with his long-term de facto partner, and he was also desperately missing his daughters. His own writings, the accounts of a fellow inmate and the content of his phone calls confirm this. While SH would talk about his concerns to other people at times, he never sought assistance from medical or other services within the Correctional Centre in relation to his feelings or his mental health.

14. On 14 December 2019 SH filled out a self-referral form to Justice Health stating that he had cut his foot on a razor while in the shower. He was concerned that he wasn't feeling well and may have used someone's needle. He was referred for a blood test. On 30 December 2019 a blood borne virus screen returned negative results.

Visits and telephone calls

15. While he was in custody his long-term de facto partner visited him on 14 and 28 December 2019. On 5 January 2020 she was denied entry for suspicion of carrying contraband.

16. The absence of visits from her during January and the lack of phone contact appears to have fuelled SH's fears that the relationship was over.

17. Eventually, on 16 January 2020 SH did speak to his partner. There were further friendly calls on 17 and 18 January 2020, with a visit booked for the morning of Sunday 19 January 2020.

18. On 18 January 2020 SH had a visit from his father and brother. To them he appeared very well.

19. For reasons that are unclear, his partner's visit on Sunday 19 January 2020 did not happen. This was a major disappointment for SH. Documents in his cell, recovered after his death reveal a level of hopelessness about himself and a desire to allow his partner to get on with her life without him.

Move to wing 11 on 17 January 2020

2 0 . On 17 January 2020 SH had been moved from 2 Wing, minimum security to 11 Wing, maximum security. The Governor of Cessnock Correctional Centre explained that this was because SH had admitted that he had suggested to other inmates that he might attempt to escape from a work area of the prison on the following Monday.

21. Correctional Services Officers had been alerted to SH's comments as a result of the prison's Intelligence Officer intercepting another inmate's call, during which the inmate recounted SH's plan to the inmate's partner.

2 2 . When approached about it, SH told Corrections Officers that, whilst he had said this, he had no intention of actually carrying out such a plan, as he only had a short period of time left to serve.

2 3 . SH's admission resulted in the decision to move him to Wing 11, a more secure Wing, notwithstanding that he had a "C1" Minimum security classification.

24. Consistent with this is an unsent letter to his partner which was found in SH's belongings after his death. It said that he had been moved to maximum security because he was caught planning to escape custody as he wanted to come home as he thought she was doing the wrong thing and she wouldn't pick up the phone.

2 5 . The conditions in 11 Wing were more restrictive that those he had experienced in 2 Wing. He no longer had access to his job during the day.

Move to cell 4128 on 19 January 2020

26. On 19 January 2020 the knock up alarm in the cell that SH was in, was not functioning properly during the weekly check.

27. SH was asked to move from his cell and was given an opportunity to choose a cellmate.

28. At 2pm he was called to the office. He said that he wanted to move into cell 4128 on the ground floor on his own.

29. SH was told that cell 4128 was unoccupied, as it was without power. He was given the option of going into that cell on the understanding that it would not have lights or power until the following day. The Corrections Officer says that SH agreed. He said SH had no electrical equipment and preferred to be on his own. As it was daylight savings it was not going to get dark until late.

30. The knock up alarm in cell 4128 had been tested that morning and was working. The electrician gave evidence that the power to the electric switches was working, and it was in fact only the lights that were out.

SH's mental state

31. The brief contains the Offender Telephone System (OTS) Call Activity Report for the period spanning 12 December 2019, until the day before SH's death (18 January 2020).

32. SH's transfer to maximum security was brought about as a consequence of intelligence gleaned from a call from an inmate to a family member, where SH's plan to escape from his workplace was obliquely referred to.

33. Similarly, his partners unsuccessful visit to the jail on 5 January 2020 and the possible plan that she was to bring contraband with her during the visit seems to have been a consequence of intelligence gleaned from phone calls she had had with SH.

34. It is clear from SH's telephone call records and the recordings of some of his calls, that he was desperately unhappy. On 16 January 2020 he told both his mother and his partner that he had been having bad thoughts and wanted to hurt himself. He was plainly very distressed.

3 5 . On 18 January, when his father and brother visited, his father described SH as "looking really good", feeling happy and looking forward to being released in the near future and seeing his daughters. It may be that his presentation that day was because of the impending visit from his partner and the fact that they were speaking to one another again.

36. The planned visit by his partner on 19 January 2020 did not take place. A booking had been made, but it was not kept.

37. Several handwritten letters and diary entries were located in SH's cell after his death. Much of this material bears a date and appears to have been written on 19 January 2020, the day of his death. Its tenor ranges from jealous and angry, to expressions of his undying love for his partner and intention to "make good" for past mistakes. There are lists of things he plans to do

once he is released, in order to win her affection and treat her like a “Queen”. He also writes about his desire to marry her and go on various camping holidays with her and their daughters.

38. His notes also contain a drawing of a stick figure hanging from a scaffold with an arrow next to the word ‘me’ and the words ‘just do it S she deserves better’.

Lock-in on 19 January 2020

39. At about 3 pm on 19 January 2020 SH is seen entering his cell on CCTV footage. At approximately 7 pm another prisoner was escorted to that cell and SH was discovered by Corrective Officers in a seated position with a ligature around his neck and secured to the top bunk. He was lifeless and resuscitation efforts were so sadly unsuccessful.

40. An autopsy was conducted, and his cause of death was determined to be neck compression occasioned by hanging.

Issues for the Inquest

41. An issues list was prepared prior to the inquest commencing to provide structure to the hearing. Some of the issues are no longer of great relevance and other issues have emerged during the inquest. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

Was it appropriate to move SH into cell 4128 without functioning lights on 19 January 2020?

42. In the OIMS records SH was allocated cell 4128 at 1:38 pm on 19 January 2020. This cell had no lighting until the electrician was to arrive the next morning. Mr Dunn, the Manager of Security at Cessnock Correctional Centre was adamant that this was not appropriate and that if there was no other available cell he should have been taken to another wing. The Governor of the Centre wasn’t so adamant.

43. At the time there was a lot of unresolved trouble with the power being tripped in the Centre by inmates using the electricity to get a spark to light cigarettes and other contraband. In fact, the electrician gave evidence that lights were not working in any of the cells on that floor. After SH death a local operating procedure[1] was developed in consultation with the unions focussing on workplace and safety. I have been informed that the new procedure has resolved the problem of having to place any inmate into a cell without lights.

44. I agree with Mr Dunn, Manager of Security that there are many issues that arise in relation to an inmate's safety that make it inappropriate for an inmate to be housed in a cell without lighting.

Why weren't the knock up records available?

45. The knock up records should always be available in an investigation into a death in custody as a matter of course. In this case the knock up records were not available as they were not obtained at the outset and the knock up system has subsequently been replaced since SH's death.

46. CSNSW have informed this court that the Investigations Branch current procedure (see CSWNSW Investigations Serious Incident Response Checklist for the Lead Investigator[2]) is that the Lead Investigator is to confirm cooperation and ongoing timely access to Correctional Centre records including cell call activity reports.

[1] Ex 1 Tab 109A
[2]

47. CSNSW confirms that the current policy is that when a critical incident occurs in a cell, the knock-up system is tested by investigators to ensure that it was operational at the time, and those recordings are downloaded for the investigators at that time. All recordings obtained by investigators are catalogued and retained on disc or external hard drive and copies are supplied with the brief. If knock-ups had occurred, those recordings would form part of the CSNSW's investigation brief of evidence. It is only in instances where a "knock-up" was not made by the inmate, there will be no recordings to produce.

48. Furthermore, CSNSW confirm that the new knock up system, JACQUES system, is now operational in all centres with audio and logs backed up and held for a minimum of 7 years. The 'Ringmaster' system which was in place at the time of SH's death is no longer operational.

Hanging points

49. The existence of hanging points in NSW prison cells has long been an issue of concern and is well documented in a number of coronial inquests. The former Governor of Cessnock Correctional Centre, Mr Murrell, gave evidence that there is a staggered program of works to remove the older style of bunk bed that was in cell 4128. The new bunks do not provide a hanging point.

How can a family or SNOK contact a Correctional Centre with welfare concerns for an inmate?

50. SH's sister had tried to bring to the attention of Cessnock Correctional Centre her concerns for SH's wellbeing. On 17 January she tried to contact the Centre and the number rang out. That wasn't the first time the number to the centre had rung out. SH had said to his mother that he had been having dark thoughts and thinking about harming himself. His sister wanted to let the authorities know.

51. CSNSW have informed the Court that following recent inquests into the death of Bailey Mackander and into the death of CJ, positive steps have been taken by CSNSW to provide family

members of inmates better telephone access. The number for the Justice Health NSW Mental Health Helpline (JH&FMHN Helpline) has been made more accessible on CSNSW's website. It is now accessible from the CSNSW home page from both the 'support' drop down on the top banner and under the 'popular content' section. Both pages contain contact details for the JH&FMHN Helpline as well as reference contacting SAPO's within the Correctional Centre directly.

52. The 'Families Handbook' is also available on the website and contains information at page 24 about psychiatric help, including the number for the JH&FMHN Helpline, as well as contact details for all correctional centres and offices from page 124. The 'Families Handbook', CSNSW advise that this is being further updated and CSNSW state that it is continuing to make efforts to improve accessibility of information to families of inmates.

53. I propose to make a recommendation to CSNSW and Justice Health NSW to conduct inter-agency consultations and implement measures aimed at continuing to improve the provision or accessibility of information to families or next of kin who are concerned about an inmate's mental health.

Conclusion

54. While he was in custody, SH was distressed about the circumstances of his relationship, and he also badly missed his children. His sister unsuccessfully tried to contact the Correctional Centre in an attempt to arrange extra support for him as she was aware that he was at risk of self-harm. She could not get in contact with anyone at the Correctional Centre. I propose to make a recommendation to improve the opportunity for families and next of kin to share their welfare concerns with the Correctional Centres.

55. I offer my sincere condolences to SH's family especially his mother who has suffered greatly since his death.

56. I close this inquest and make the following findings and recommendations.

Findings:

I find that SH died on 19 January 2020 at Cessnock Correctional Centre, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.

Recommendation:

To the Chief Executive Officer, Corrective Services New South Wales and to the Chief Executive Officer, Justice Health, and Forensic Mental Health Network New South Wales:

I recommend that Corrective Services NSW and Justice Health NSW conduct inter-agency consultations and implement measures aimed at further improving the provision or accessibility of information to families and next of kin who are concerned about an inmate's mental health.

Magistrate C Forbes
Deputy State Coroner
16 August 2023
Coroners Court of New South Wales, Lidcombe