CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Steven McHugh
Hearing dates:	11 October 2023
Date of findings:	11 October 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate E Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – mandatory inquest – intentional self harm – plastic bags
File number:	2022/00095990
Representation:	Ms Xanthos, Coronial Advocate, Assisting Coroner Mr V Musico Solicitor, appearing with Mr Nickson of the Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Ms McPhee of Counsel instructed by Mr Karamjee, representing the GEO Group Pty Limited

Findings:	**The identity of the deceased** The deceased person was Mr Steven McHugh **Date of death** Between 31 March and 1 April 2022 **Place of death** Junee Correctional Centre, Junee, New South Wales **Cause of death** Plastic bag asphyxia **Manner of death** Intentionally self-inflicted
Recommendations	Nil
Non-Publication Orders	Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

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INTRODUCTION

1. This is an inquest into the death of Steven McHugh who died between 31 March and 1 April 2022 at Junee Correctional Centre. He was 60 years old at the time.

The purpose of the inquest

2. The coroner's primary function is set out in s. 81 of the *Coroners Act 2009*. It is to make findings as to the identity of the person who has died, the date and place of their death and the manner and cause of death. The inquest is not adversarial, but inquisitorial. The focus is to determine what happened without attributing blame, guilt or making findings of liability.

3. In this case, there is no controversy as to identity, date or place of death nor manner and cause of death.

4. Section 23 of the *Coroners Act* NSW grants jurisdiction to the Coroner to hold an inquest, where a person has died:

> *"While in the custody of a police officer or in other lawful custody"*

5. This is therefore a mandatory inquest pursuant to section 23 Coroners Act 2009. When any inmate dies in custody the Act requires that a Senior Coroner undertakes an inquest. This is important given those inmates are reliant upon the care of the State, and have no ability to access any necessary care or treatment. It is incumbent on the State to ensure that necessary and appropriate medical and psychological treatment is provided.

1. Background to Mr McHugh

1.1. Mr Steven McHugh was born on 24th June 1961. Mr McHugh in August of 1998 began a relationship with a woman who already had two children from a previous relationship. He moved into their home in the state of Victoria before re-locating to New South Wales 12 months later. It was during this time that allegations were made against him resulting in his arrest and subsequent conviction where he was sentenced to a term of imprisonment for 7 years in Victoria.

1.2. Following this conviction, Victoria Police alerted New South Wales Police to the allegations made against Steven and the likelihood some of his offending behaviour taking place in this state. Detectives from Deniliquin police station reviewed the evidence and on 10 August 2016, arrest warrants for Mr McHugh were made at Albury Local Court. Upon completing his sentence in Victoria, he was released from

Ararat Correctional Facility on 22 March 2022 and immediately arrested and extradited to New South Wales.

2. Events in New South Wales

2.1. On 22 March 2022, Mr McHugh appeared at Stawell Magistrates Court and was then extradited to Deniliquin where the arrest warrants were executed. The following day he appeared at Albury Local Court where he was formally bail refused. He was transported to Junee Correctional Centre (CC) and into the care of New South Wales Corrective Services (CSNSW).

2.2. Upon his admission at Junee CC, Mr McHugh completed an *Inmate Request Form* disclosing that he held fears for his safety due to the context of the allegations he was facing. This request was supported by the Correctional Manager Operations (CMO) and classified as a Special Management Area Placement (SMAP) where he was placed in protective custody. Mr McHugh was housed alone. He commenced a 14-day isolation period as part of COVID-19 protocols at the time. He continued to be monitored for flu-like symptoms and was subjected to RAT tests. During this time, he remained negative to COVID.

2.3. On 29 March 2022, he appeared in Albury Local Court. Another request for release was made where he was assisted by Legal Aid. His application included that he would reside with his mother in Victoria. Subsequent to his death, handwritten notes were located outlining his reasons for seeking release where he wrote, "*It would be mentally better for me to be at home with family*." Mr McHugh remained close to his elderly mother and he wanted to be with her in her final years. The application was unsuccessful with the charges being adjourned until 7 June 2022.

2.4. About 16:47pm on Thursday 31 March, Mr McHugh and the other inmates were locked in for the night. Each inmate was physically checked and their meals handed to them with an overnight ration pack and one cup of hot water. Subsequent checks were performed during the night at 19:07, 00:25 and 05:00am. These were visual inspections when officers look through the window on the cell door to ensure the inmates are in their beds.

2.5. At 7:13am on Friday 1 April, three correctional officers entered the Pod to commence the morning muster head count. The process required inmates to present themselves at their cell door for visual inspection and a verbal wellbeing check. The correctional officers were unable to raise him after knocking on the door and calling out to him. They entered the cell and found Mr McHugh lying face down on the bottom bunk covered by a green sheet. From the cell door, his head was

obscured by the shower wall. They removed the sheet and saw a black plastic bag over his head. A correctional officer immediately tried to rip the bag off, and another officer used his Hoffman knife to cut the bag open. At that point Mr McHugh was unresponsive

2.6. The officers moved Mr McHugh by picking him up from the mattress and placing it on the ground outside the cell to give themselves room to render first aid. Cardiopulmonary resuscitation was commenced. New South Wales Ambulance were called at 7:17am. At 7:22am Justice Health nurses arrived and coordinated life preservation efforts by inserting a guedel airway with oxygen administration via a Laerdal bag. CPR continued with an AED until paramedics arrived determined at 7:42am that he could not be revived. Police were called and Steven's death was reported to the coroner pursuant to section 23 of the *Coroners Act 2009*.

2.7. An examination was performed by the Department of Forensic Medicine at Newcastle where the cause of death was recorded as '*Presumed Plastic Bag Asphyxia*'. Routine toxicology found no alcohol or drugs in the specimens analysed.

3. Investigation into Mr McHugh's death

3.1. Following Mr McHugh's death, his cell was examined. A pair of glasses and some paperwork were found along with the dinner from the evening before that remained untouched. There was a small resealable bag with medications prescribed to him. Otherwise, there was nothing remarkable found and no suicide note was left.

4. Medical background

4.1. In reviewing his Justice Health records in Victoria, Mr McHugh last attended a health clinic on 7 March 2022 where he visited the physiotherapy clinic for muscular pain in the left shoulder. He had many injuries, mostly obtained from working on a farm as a diesel mechanic as part of a job release program. Case notes reflect that he was very active and maintained his fitness by going to the gym regularly.

4.2. When he first entered custody, reports indicated Mr McHugh had psychology appointments to assist with anxiety related to entering into custody for the first time. Notes recorded over the subsequent years described how he maintained his mental health through exercise. In the last 12 months of his sentence, he visited the clinic approximately 50 times but none of those visits related to his mental health. At no time were there reports of him being at risk or attempting self-harm. The only risk identified was the threat from other inmates due to the context of his offending.

4.3. Not long after he commenced his sentence in Victoria, Mr McHugh was aware of what would transpire upon his release and the likelihood of him being extradited to NSW. In February 2021 it was recorded by his case worker:

> *Steve has been working with myself and a criminal lawyer from Legal Aid NSW on the further charges he is facing in NSW…Steve will serve his full sentence on the 18 April 2022. He will be transferred to NSW and face his charges from there, I have been told…they will look at the total time he would have received if his charges had all been dealt with together…and make a decision as to whether he needs to serve extra time. Steve is aware of all this and although he is nervous at the prospect of NSW prisons just wants it all sorted out…*

4.4. Just prior to his release, he made a request for the phone number of Wagga Legal Aid office. He indicated at that time that his mental health was good and his sentence in Victoria was assisted by having weekly visits from family and friends. When Mr McHugh first entered into NSW custody, the only health condition he complained about was his back where he had prescriptions for Glucosamine, Paracetamol and Meloxicam, which continued to be administered at Junee.

4.5. A Reception Screening Questionnaire by Justice Health was completed with the RSA Clinical Summary recording that he was experiencing concerns about the likelihood of getting bail, the distance from his family and absence from his 94-year-old mother. During a sixty minutes assessment by a registered nurse he was recorded as presenting with good future planning and noted that he denied thoughts of self-harm.

Concluding remarks.

1.1. There was no controversy as to Mr McHugh's identity, date or place of his death, nor the cause or manner of his death.

1.2. Thorough investigations by Detective Senior Constable Cooper satisfied the inquest that there was no third-party involvement, and no suspicious circumstances.

1.3. He was last seen alive at 17:00:19 where CCTV captures correctives officer checking in with him. In her evidence, that officer discloses that she checked to ensure all cell doors were locked. She recalled seeing Mr McHugh standing in his cell. The following checks conducted overnight would only have been to note him lying in the bed, and as he was in his bed, there was no suspicion of self-harm.

1.4. CSNSW have been working on, and continue to review, safeguards to mitigate the opportunity for inmates to take their own lives. In a statement from the Director of

GEO Group and General Manager of Junee CC it was noted that since Mr McHugh's death, garbage bin liners were removed from cells in the accommodation units and only used in common areas. They are also no longer being used to distribute items to inmates for buy-ups. In addition, The General Manager of Statewide Operation of CSNSW confirmed that Custodial Operations Policy and Procedure 3.7 has since been amended to limit and oversee the access and distribution of garbage bags to inmates.

1.5. As a result of the attention given to this matter, and subsequent improvements, no recommendations are to be suggested in this inquest.

1.6. This was an unexpected and sudden loss for the family and friends of Mr McHugh. There were no warnings given in relation to any demise in Mr McHugh's mental health state, he did not indicate to anyone that he was harbouring any such thoughts and it came as a shock to all involved. He was experienced in the custodial setting and had managed through a long period of incarceration without demonstrating any significant mental health issues, nor did he seek any treatment for mental health.

Acknowledgments

6. Thank you to Ms Xanthos, Counsel assisting for working to determine whether there were to be any issues arising from the inquest and ensuring, through careful examination of the evidence, that Mr McHugh had received adequate care while in custody.

FINDINGS

7. I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased
The deceased person was Mr Steven McHugh

Date of death
Between 31 March and 1 April 2022

Place of death
Junee Correctional Centre, Junee, New South Wales

Cause of death
Plastic bag asphyxia

Manner of death

Intentionally self-inflicted

Thank you to Mr McHugh's sister for attending the inquest and I extend my sincere condolences to her and the family and friends of Mr McHugh for their loss.

Deputy State Coroner

Magistrate Kennedy

11 October 2023