CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Alex Clements
Hearing date:	31 May 2024
Date of findings:	31 May 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person in custody – was medical treatment appropriate – were cell searches adequate.
File number:	2020/235801
Representation:	Coronial Advocate assisting the inquest: Senior Constable Kai Jiang Ms Janet De Castro Lopo for the Commissioner of Corrective Services NSW Ms Seun Idowu for St Vincent's Correctional Health Mr Shaun Bailey for MTC Broadspectrum.

Findings:	**Identity** The person who died is Alex Clements **Date of death**: Alex Clements died on 12 August 2020. **Place of death**: Alex Clements died in Parklea Correctional Centre, NSW. **Cause of death:** Alex Clements died as a result of hanging. **Manner of death:** Alex Clements died as a result of a self inflicted act with the intention of ending his life, while he was in lawful custody.

Non publication orders pursuant to sections 74(1)(b) and 65(4) of the Coroners Act 2009 have been made in this inquest.
A copy of the orders can be found on the file in the Coroners Court Registry.

Section 81(1) of the Act requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Alex Clements.

Introduction

On 12 August 2020, Alex Clements aged 24 years died in his cell at Parklea Correctional Centre.

On the afternoon of 12 August 2020, Alex was found hanging from a ligature which had been tied to a sprinkler head in the ceiling of his cell. Emergency help was quick to arrive, but tragically Alex could not be revived. He was pronounced deceased.

A post mortem examination confirmed that the cause of Alex's death was hanging. There were no suspicious injuries. Toxicological analysis detected only the presence of Alex's prescribed medication, the antidepressant sertraline.

An inquest into the circumstances of Alex's death is mandatory pursuant to section 27(1) (c) of the Act, as he died while he was in lawful custody.

The role of the Coroner

A Coroner holding an inquest must record in writing their findings as to the date and place of the person's death, and the cause and manner of death.

In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

Alex was born on 30 October 1995 in the United Kingdom. In February 1997 his mother Ms Hayley Harrington brought Alex and his sister to Australia to live with her and her parents.

Ms Harrington said that during Alex's school years he was subjected to bullying. After leaving school Alex worked as an apprentice electrician with Ms Harrington's husband, Brett Harrington. Unfortunately he developed a dependence on alcohol and illicit drugs, and he left home. His dependence led to a deterioration of his mental health, and he suffered the effects of impulsivity, anxiety and depression. He had various hospital admissions due to thoughts of self harm and suicide.

In 2015 Alex met Brittany Murdoch and they had a son, Kaison, in June 2017. However the following year Alex received a sentence of imprisonment after being convicted of offences of domestic violence upon Ms Murdoch.

When he was released on parole in 2019 Alex lived for a while with his mother, but he relapsed into drug use. He then lived in shared accommodation in Ruse, NSW, and commenced a relationship with Tamara Viles.

Then on 13 July 2020 Alex was charged with further domestic violence offences. He was refused bail and his parole was revoked. He was transferred to Parklea Correctional Centre [Parklea CC] and was eventually placed in Cell 29 of Unit 1A.

In Parklea CC Alex contacted his mother by phone each day. He told her that he loved her and was sorry. Ms Harrington said that he did not sound happy. She arranged to have a video visit with him on 16 August 2020, but tragically Alex died before this could take place.

<u>Medical history in Parklea CC</u>

Alex's last mental health admission had been in Campbelltown Hospital in June 2020, just before he was charged with the above offences. When he was discharged from hospital on 26 June 2020 he was prescribed with sertraline and Seroquel.

When Alex went into custody at Parklea CC he had a health screening assessment which was performed by staff of St Vincent's Correctional Health [SVCH]. SVCH is

the company which provides health services to Parklea inmates. Alex was placed on a wait list to receive a mental health review.

Following the initial health assessment, SVCH staff continued Alex's prescription for sertraline but discontinued Seroquel. Seroquel was only prescribed for inmates who had been diagnosed with schizophrenia or bipolar disorder. Alex however reported that he had been using it to assist with sleeping problems.

SVCH staff therefore sent a request to Campbelltown Hospital on 16 July 2020, seeking confirmation of Alex's prescription with Seroquel. A lengthy delay followed before they received a response. For unknown reasons Campbelltown Hospital did not receive the request, and no one at SVCH followed this up until 5 August 2020. The medical records were finally received by SVCH staff on 11 August 2020, the day before Alex died.

The events of 12 August 2020

Alex was accommodated in a cell which he shared with another inmate. Late on the morning of 12 August 2020, on a number of occasions Alex tried without success to call his mother.

At about 12.30pm correctional officers began to escort inmates out for the lunch period. Alex's cell mate left their cell, but Alex remained lying on his bed on the top bunk. CCTV footage shows that soon after the cell mate left, the cell door was closed from the inside.

At 12.45pm correctional officers carried out a check of the cells in the wing. They opened the door to Alex's cell and looked around inside, then left, locking the cell door from the outside.

There was a further inspection of Alex's cell at 1.20pm, when a correctional officer carried out a standard inspection for obvious contraband items. The officer opened the cell door and looked around while standing at the doorway, then left, locking the door behind him.

Neither of the two cell inspections revealed that Alex was still inside the cell.

At 3.10pm it was standard procedure for inmates to return to their cells for the evening 'lock in'. Alex's cell mate waited outside their shared cell for correctional officers to unlock the door and let him in. The cell mate then entered the cell, and immediately saw Alex suspended in the centre of the cell from a ligature which had been tied to a ceiling sprinkler. He ran out and alerted correctional officers, and Alex was brought down onto the floor. CPR efforts commenced immediately, and were taken over by

SVCH medical staff. Sadly, Alex could not be revived and he was pronounced deceased.

The coronial investigation

A coronial investigation commenced that afternoon. Alex's cell was secured, and police obtained statements from Alex's family members and correctional staff. They also gathered medical records from Campbelltown Hospital and SVCH.

Police established that the ligature which Alex used had been fashioned from prison issue bed sheets. Alex had left an envelope in his cell, with letters for his mother, Ms Murdoch and their son, Ms Viles, and his sisters. These letters expressed his love for them and his regrets for the way his life had turned out.

The investigation also established that Alex had last entered his cell at 12.07pm that day and had not left it. Nor had anyone entered the cell after 1.24pm, until Alex's cell mate returned at 3.10pm.

It appears likely that on the two occasions when correctional staff came to check the inside of Alex's cell at 12.45pm and 1.20pm, he was hiding either under the bunk bed or behind closed shower curtains.

An examination of Alex's phone calls over the previous days showed that he had daily contact with his mother. He expressed concern to her that he was not receiving Seroquel, and concerns about his personal safety.

However, the police investigation did not find that anyone else had been involved in Alex's tragic death.

Issues at the inquest

There is no doubt that the enquiries carried out by SVCH about Alex's Seroquel were unacceptably delayed. This was acknowledged by SVCH. In November 2020, new procedures commenced which require staff to meet a timeframe for prioritising requests about medication which had not been completed. This process is also digitalised to improve transparency and accountability.

An expert report was sought from forensic psychiatrist Dr Danny Sullivan, as to whether the fact that Alex was not receiving Seroquel while in Parklea CC was likely to have contributed in any way to his decision to take his own life. Dr Sullivan considered this was unlikely, as Alex's previous use of Seroquel had not been for the treatment of an active mental illness that was relevant to his suicide.

A second concern was the adequacy of the cell checks which had been conducted at 12.45pm and 1.20pm on 12 August 2020. Neither of the two cell checks had detected that Alex was still inside his cell. Nor apparently had correctional staff been aware that Alex was not present and accounted with all the other inmates in his wing, when they were cleared out for the lunch period.

After Alex's passing there was a review of the applicable policies and procedures, and some changes were introduced. Correctional staff are now audited to ensure they are aware of their responsibility to account for the presence of inmates. They must ensure that each inmate is identified when an accommodation area is cleared for let go and lock ins. Additionally they are to improve the vigilance of their cell searches to ensure inmates are not hiding.

Conclusion

In light of the measures which Parklea CC has introduced as a result of Alex's tragic death, there is no requirement for this inquest to make recommendations to improve its procedures for medication requests and for the adequacy of cell checks.

It is immensely sad that Alex died at such a young age, and in an emotional condition where he did not feel that he could continue to live. His mother and Mr Harrington attended the inquest, bearing witness to the love they held for him. On behalf of everyone at the Coroners Court, I convey sincere sympathy to Ms Harrington and her family for the loss of Alex.

I thank Coronial Advocate Kai Jiang for his assistance and conduct of the inquest, and Detective Christopher Lehrer for his coronial investigation.

Findings required by s81(1) of the Act

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.

Identity
The person who died is Alex Clements.

Date of death:
Alex Clements died on 12 August 2020.

Place of death:
Alex Clements died in Parklea Correctional Centre, NSW.

Cause of death:
Alex Clements died as a result of hanging.

Manner of death:
Alex Clements died as a result of a self inflicted act with the intention of ending his life, while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe

14 June 2024.