CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jasmynd Gibbs
Hearing dates:	6-7 September 2023, 16 November 2023, 24 November 2023 (Family Statement)
Date of findings:	20 February 2024
Place of findings:	NSW Coroners Court Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death due to complications of methylamphetamine use; death of a person on supervised parole; wrap around support for parolees with complex needs;
File Number:	2021/129807
Representation:	Ms R Rodger, Counsel Assisting, instructed by Ms S Crellin (Crown Solicitor's Office) Ms D White for the Commissioner of Corrective Services New South Wales, instructed by Department of Communities and Justice Ms E Phelan for [redacted], instructed by Dowson Turco Lawyers

Non publication orders:	Non-publication orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, including corresponding orders pursuant to section 65(4) of the Act, can be found on the Registry file.
Findings	**Identity** The person who died is Jasmynd Gibbs. **Date of death** Jasmynd Gibbs died on 7 May 2021. **Place of death** Jasmynd Gibbs died at John Hunter Hospital, Newcastle. **Cause of death** Jasmynd Gibbs died of complications of methylamphetamine use. **Manner of death** His death occurred in circumstances of a drug relapse whilst on supervised parole. Jazzy had complex needs and required comprehensive "wrap-around" support which was not available.
Recommendations	**To the Commissioner of Corrective Services** 1. That the Commissioner of Corrective Services advocate for an increase in both funding and the roll out of wrap-around services for parolees with complex needs including case managers such as those provided by the Community Restorative Centre consistent with the recommendations 99 and 102 of the special Inquiry into the drug 'Ice". 2. That the Commissioner of Corrective Services review training on mental health and complex support needs to identify whether it meets the

	needs of Community Corrections Officers. 3. That the Commissioner of Corrective Services review Community Corrections Policies and Practices to ensure continuity of service to complex support needs parolees by their designated Community Corrections Officer. 4. That the Commissioner of Corrective Services consider the publication of an information sheet on the role of Corrective Services NSW, the aims of community based supervision and the ways in which non-government organisations can support the management of offenders in the community. **To the Secretary of the Department of Communities and Justice** 5. That the Secretary of the Department of Communities and Justice consider a long term strategy to move away from heavy reliance on motel accommodation for parolees at risk of homelessness, which must involve strategies such as increased funding for Specialist Homelessness Services that can provide wrap-around services. 6. That the Secretary of the Department of Communities and Justice continue the refinement of procedures, as appropriate, requiring annual inspections of Temporary Accommodation providers to ensure ongoing suitability. 7. That the Secretary of the Department of Communities and Justice continue collaboration with Corrective Services NSW to provide housing assistance for inmates and parolees who are at risk of homelessness, including the development of a Housing Portal on inmate tablets which provides information about

	housing services, products and assistance prior to release from custody. 8. That the Secretary of the Department of Communities and Justice consider the development of an information pack to be provided to Temporary Accommodation (TA) providers, outlining annual inspections that are to be completed by DCJ Housing offices or Social Housing Management Transfer location community housing providers (SHMT CHPs) as well as the contact details for any complaints raised by the TA provider or TA guest.

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Introduction

1. This inquest concerns the death of Jasmynd Ashraf Gibbs. Jasmynd, known as Jazz or Jazzy to his family and friends, was only 33 years of age at the time of his death. He was a proud First Nations man who was loved and supported by his partner and his family. He died on 7 May 2021 at John Hunter Hospital, NSW, slightly less than two months after his release from prison to supervised parole on 18 March 2021. His death was ultimately caused by "complications of methylamphetamine use."

2. At the time of his death, Jazzy had complex support needs arising out of a history of childhood trauma, substance abuse, mental illness and a suspected brain injury or cognitive disability. He was living in temporary motel accommodation, was not engaged in counselling or drug and alcohol treatment and had no local medical support.

3. Jazzy was so much more than the circumstances he struggled with. In her family statement, Jazzy's mother described him as having a love of music, driving, gardening and sewing. He enjoyed spending time in nature and with his family. He was also fond of attending football games. Jazzy is remembered as "a kind generous soul, a shiny diamond in the rough."

4. Jazzy's mother, step father and partner attended this inquest seeking answers and in the hope that a close examination of the circumstances surrounding Jazzy's death might shine a light on opportunities to create change for others caught up in the parole system, particularly those struggling with the drug ice. I thank them for their attendance and for their courageous participation in these proceedings. Their heartbreak was palpable as the evidence emerged. I acknowledge their profound pain and grief and respect their commitment to fighting for changes that might assist others.

The role of the coroner and the scope of the inquest

5. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

6. A list of issues was prepared before the proceedings commenced. These issues guided the investigation and focused on support procedures in place in the lead up to Jazzy's death. [3]

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] 1. Was the management of Mr Gibbs relocation to Raymond Terrace reasonable and appropriate (including with reference to relevant Housing and Community Corrections Policies and Procedures at the time) including:
i. Assessment of risks relating to the move;
ii. Assessment of prosocial supports relating to the move;

The date, place and medical cause of Jazzy's death was not in dispute. For this reason the proceedings focussed on the manner or circumstances of Jazzy's death. The court was keen to understand how a much loved man, on a supervised parole order could end up in such bleak circumstances so soon after his release from custody. Were adequate supports in place? What more could we have done, as a community, to ensure his safety? How many others face similar difficulties on their release from custody? These were the kinds of questions raised by the evidence presented.

The evidence

7. The court took evidence over four hearing days. The court also received extensive documentary material in seven volumes. This material included witness statements, medical records, various policies and procedures, and the report of an independent expert, Professor Eileen Baldry. Professor Baldry is an Emeritus Professor of Criminology and Law and Justice at the University of NSW. She has over 30 years' experience in the field of social policy, social development and criminology. Professor Baldry's research has focused on many issues relevant to this inquest including access to justice, indigenous health and the transition from custody to the community. More specifically, Professor Baldry has done in depth research regarding Indigenous people and mental health disorders and cognitive disabilities and how they are managed by agencies such as community corrections.

8. The inquest heard oral evidence from nine witnesses who described the support Jazzy was provided after his release from custody and gave insight into aspects of his life in the weeks leading up to his death.

9. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed. Counsel assisting provided a useful chronological summary in her closing submissions. I rely heavily on that document to set out the uncontroversial material, taking into account the submissions made by the parties where factual disputes or differences of emphasis were raised. All conclusions are my own.

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iii. Assessment of appropriateness of residence (including what accommodation was available and how such accommodation is funded);
iv. Assessment of the use of electronic monitoring during the period immediately after relocation;
v. Arrangement of protective factors prior to move such as GP and psychologist;
vi. Engagement with family as to the appropriateness of the move;

2. Was the management of Mr Gibbs once he had relocated to Raymond Terrace reasonable and appropriate (including with reference to relevant Housing and Community Corrections Policies and Procedures at the time) including:
i. Provision of assistance in arranging GP and psychologist;
ii. Administration of drug testing;
iii. Direction regarding abstinence once relapse was reported and whether any assistance provided in developing strategies or connecting to drug and alcohol counselling;
iv. Maintenance of supervision once relapse reported and contact lapsed;
v. Engagement with family as to concerns about Mr Gibbs relapse;
vi. Extent of supervision provided by accommodation;
vii. Provision of assistance to arrange alternative accommodation once eviction notice from the temporary motel accommodation was given to Mr Gibbs.

3. Was the management of Mr Gibbs by Community Corrections reasonable?

The context to Jazzy's death

10. It is necessary to place Jazzy's death in its wider social context prior to examining the particular facts. This court has many times stated that the over-representation of First Nations people in custody is a national disgrace.[4] It should be remembered that the over-representation of First Nations people is present at every level of the criminal justice system, including in relation to their contact with Community Corrections.[5] It appears likely that many of Jazzy's issues would have been better dealt with outside the criminal justice system, given the inadequate support he received for his mental health, cognitive disability and long term drug and alcohol issues in custody and on periods of prior conditional release.

11. In trying to unpack what services were actually available to support Jazzy on his supervised release, it was necessary to understand what Community Corrections could offer and what was available through other services offered by entities controlled or funded by the Department of Communities and Justice. Understanding the complex way funding operates for services for people who may be homeless or be at risk of homelessness was no easy task. However, the bewildering structure of support did not hide the basic truth that the sector is grossly underfunded and the consequences of this are devastating. It is an issue to which I will return.

12. It must also be stressed that Jazzy's death occurred in the context of his binge use of the drug ice. The Special Commission of Inquiry into crystal methylamphetamine and other amphetamine-type substances (the Ice Inquiry) examined in detail the use and impact of ice and other illicit amphetamine-type substances in NSW as well as examining options to improve the way we respond to the issues raised. In 109 recommendations released in 2020, the Ice Inquiry highlighted the need for very substantial reform across the criminal justice and health systems to tackle the significant social and health harms caused by ice. Of relevance to these proceedings, The Ice Inquiry called for an urgent increase in government resourcing for drug rehabilitation and treatment, especially in rural, regional and remote NSW. As will become clear, while the government have actioned some of the recommendations, there remains significant work to do. At the time of Jazzy's death there existed very few treatment options that would suit his complex needs and it seems none were immediately available. It was particularly concerning that workers who gave evidence in this inquest in 2023 indicated they had not yet felt the improvement they had expected following the significant work of the Ice Inquiry[6]

[4] Inquest into the death of Kevin Francis Bugmy (6 July 2022); Inquest into the death of Reuben Button (21 July 2023) among others.
[5] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, [9].
[6] Kylee Anderson, Transcript, 6 September 2023, p71; Morgan McCarter, Transcript, 7 September 2023, p22.

13. Professor Baldry drew this court's attention to a key principle that emerged from the extensive evidence presented to the Ice Inquiry – that is that effective responses must recognise and address the social determinants of ATS use, including trauma[7]. Dependent use in particular frequently occurs in the context of broad socioeconomic disadvantage and trauma where use is a symptom, rather than the cause of a person's problems. The Ice Inquiry paid particular attention to the needs of Aboriginal communities where the impact of crystal methylamphetamine is disproportionate because it aggravates the substantial socioeconomic disadvantage and trauma already experienced in those communities. The significant learnings from that inquiry must not be lost.

14. Professor Baldry stated that "Mr Gibbs' death from a fatal ICE binge was the final tragic outcome in a persistent cycle over 20 years of serious mental health episodes, AOD use, in and out of prison, attempts to stabilise his MH and abstain from AOD, then further MH episodes and AOD use continuing the cycle. It was not caused by an individual CC officer, an individual housing manager or any other specific individual…It was the result of decades of lack of education, disability, mental health, child protection and other social services provision that Mr Gibbs had a right to."[8] I accept her view and acknowledge her words sum up the relevant context to any investigation of Jazzy's death.

Background and brief chronology

15. Jazzy was born on 6 August 1987. He grew up in a number of places including Marrickville. His mother [redacted] is a proud Kamilaroi woman who raised both Jazzy and his younger sister [redacted] after she separated from their father [redacted] when Jazzy was seven years old. In her family statement she laid bare the inter-generational trauma and disadvantage she and her family have experienced and I thank her for her open and generous interaction with this court.

16. [redacted] and her husband [redacted] participated in these proceedings from the outset, despite her extremely poor health. Her commitment to her son was steadfast and her significant grief at his untimely death was palpable in the court room.

17. The court was informed that as a young boy Jazzy was sociable and well-liked, he had a good disposition and was very kind. As a young man he was relaxed and sociable and happy to be with his family members, including his grandmother who he lived with in Dubbo for a time. He enjoyed being in nature, gardening and the bush.

[7] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, [9].

[8] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, [10].

18. Jazzy was in a relationship with [redacted] for five years before his death. Their relationship had difficulties, no doubt exacerbated by Jazzy's background of trauma and issues arising from his ongoing addiction. Nevertheless they remained close. [redacted] attended the inquest and was visibly devastated by her loss. I offer her my sincere condolences.

History of mental health, drug use and incarceration

19. In a report to a psychiatrist in 2015, Jazzy described the period of his life from 8-16 years as unsettled, moving from town to town with his mother and spending some time with his maternal grandmother in the country. He also lived in Boy's Homes at 15 and 16 years of age and there was a period when he lived on the streets. He told the psychiatrist that he had experienced violence in the home and in the Boy's Homes, and that he had been in and out of custody since he was 19 years of age.[9] I accept Jazzy had a significant trauma history and find it most likely that he suffered its lasting effects throughout his life. I note his mother described him as eventually having become institutionalised.[10]

20. Jazzy told the psychiatrist that he had commenced use of cannabis at 13 years, ecstasy, speed and LSD from 19 years of age and methamphetamine from 22 years of age.[11]

21. Corrective Services NSW (CSNSW) records show that Jazzy engaged in residential drug rehabilitation in 2012 and 2014.[12]

22. Jazzy's medical records also disclose a history of mental illness, variously diagnosed as schizophrenia, schizoaffective disorder, bipolar disorder, anti-social personality disorder, depression and anxiety, substance abuse disorder, and self-harm noting a history of childhood trauma.[13] I accept the family submission that the available records disclose sub-optimal treatment for these mental health issues over many years.

23. After Jazzy suffered head injuries in 2014 his mother noticed that he behaved differently as he became less responsible, had trouble remembering things, lacked organisational skills and became more aggressive. It is concerning to see little formal acknowledgement and few treatment strategies for his cognitive impairment in the custodial records.

24. The records show that Jazzy had first been sentenced to full time imprisonment as an adult in 2006 and had further periods of incarceration thereafter which included periods when he

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[9] Vol 1, Tab 7c, p51-52.
[10] Vol 1, Tab 7, Statement of [redacted], [19].
[11] Ibid at p56.
[12] Vol 1, Tab 9z, Pre-Sentencing Material, p114.
[13] Vol 3, Tab 13, Justice Health Records Part A, p14, 43, 105, 127, 142-143, 176, 209-211, 330, 343, 347 and 401; Vol 5, Tab 14, Family Circle Medical Practice Records, p88; Tab 9, Pre-Sentencing material, p60.

was supervised on parole. Notably, Jazzy's mental health appeared to deteriorate, and he had re-offended when previously released to parole at both his mother's home in the Sydney suburb of Burwood and in the Raymond Terrace area where his partner lived.[14]

25. I accept counsel assisting's submission that Jazzy's most recent period of incarceration arose out of domestic violence offences which are relevant to this inquest only in so far as they resulted in the period on parole which is the focus of the inquest; and that they are relevant to decisions made in relation to the suitability of his accommodation - given that there was an AVO that he not go within 100m of [redacted] home in Raymond Terrace.[15]

26. I note that [redacted], who was victim of these offences informed the court that it was her understanding that while incarcerated Jazzy did not use drugs. I note that she remained supportive on his release.

Supervision on Parole by Community Corrections

27. Planning for Jazzy's release commenced when he was still in custody.

28. A Risk Mitigation Plan (RMP) was developed on 17 February 2021 by NSWCS in preparation for his release which relevantly noted the following:

    (1) Prosocial influences include his mother's willingness to assist him to remain abstinent, engage in treatment as required by a local AMS family doctor;

    (2) Risk factors for reoffending in relation to domestic violence may result in a direction to not enter the entire suburb of Raymond Terrace;

    (3) Prior domestic violence offending against his mother in 2017 resulting in 20 hour standoff with police;

    (4) Ice and cannabis use are risk factors in offending;

    (5) Must remain abstinent and if he failed to do so a period of detoxification followed by residential drug and alcohol treatment could be directed;

    (6) Mother indicated he must remain engaged in mental health treatment in order to achieve overall stability;

    (7) Mother believes childhood trauma, loss and grief issues combined with potential borderline personality disorder, impacts on his overall functioning in the community;

[14] Professor Eileen Baldry, Transcript, 16 November 2023, p37.
[15] Vol 1, Tab 9, Pre-Sentencing material, p150.

(8) Must have culturally appropriate post release support workers and/or case management services for additional assistance with responsivity and engagement support;

(9) Mother will organise psychologist who specialises in Aboriginal issues and refer to local GP for MHCP.[16]

29. On 18 March 2021 Jazzy was released to parole to reside with his mother [redacted] at her address near Burwood. His mother provided strong support for his return to their home and was happy to have Jazzy reside with her and her husband as "they all got along well". [redacted] provided support for Jazzy to attend the local General Practitioner (GP) and the Aboriginal Medical Service (AMS) that knew him and his history well. Records show that [redacted] expressed concern that the management of Jazzy's mental health and his abstinence from drugs were the biggest risk factors and that he would be better able to maintain abstinence whilst residing with her rather than returning to Raymond Terrace.[17]

30. Jazzy was allocated a Community Corrections Officer (CCO) at Burwood Community Corrections (BCC), David Plowright, and was required to comply with a number of parole conditions which relevantly included conditions to cease drug use and to comply with drug testing.

31. Five days after Jazzy's release on 23 March 2021, he telephoned BCC advising that he was too stressed at his mother's place and that he needed to "go back to the country". He was advised to find accommodation for the night in the Burwood area, "stay away from mums place if that was a trigger for him" and then attend the BCC office the next day where they could assist him in finding accommodation.[18] The Inquest heard evidence from Professor Baldry that it is common for parolees to be released to their parental home and in more than half of those cases the arrangement breaks down shortly after release and the parolee seeks to relocate.[19]

32. On the same date records show that BCC considered a post release plan:

(1) Consideration be given to EM anklet and twice weekly reporting during period of accommodation instability;

(2) Regional NSW as a viable alternative will need advance planning and pre-approval;

[16] Vol 1, Tab 9, Pre-Sentencing material, p163-173.
[17] Vol 1, Tab 10, OIMS Case Notes, p212.
[18] Vol 1, Tab 10, OIMS Case Notes, p219.
[19] Professor Eileen Baldry, Transcript, 16 November 2023, p37-38.

(3) Conduct of review into break down of post release plan including liaison with family members.[20]

33. The next day, on 24 March 2021, Jazzy spoke to his CCO Mr David Plowright over the phone to discuss a possible move to Dubbo as he felt his current accommodation was too small, that he was not coping with city life but that he was getting on well with his mother.[21]

34. On that same day, Mr Plowright telephoned Jazzy's mother who said that Jazzy was doing very well at home having settled more quickly than on his previous releases from custody, although she reported that he had told her he was having suicidal feelings the day prior. [redacted] said that his girlfriend [redacted] was staying over occasionally, and that she believed Jazzy wanted to move to Dubbo to pursue a relationship with his estranged father.

35. The next day, 25 March 2021, [redacted] was in contact with Mr Plowright again to let him know about some alcohol use by Jazzy and to advise him that Jazzy had pressured her for money. Mr Plowright indicated that he would discuss those issues with Jazzy when he came in for his scheduled appointment that day. It is clear that [redacted] was fully committed to open communication with Mr Plowright.

36. When Jazzy attended later that day he reiterated that he wanted to move to the country as his parents' place was too small and "he [was] a country boy". Jazzy stated that Kylee Anderson from the Port Stephens Family Neighbourhood Service (PSFNS) had found him accommodation. Mr Plowright explained to Jazzy that due to his high risk and history of re-offending, a management plan needed to be put in place before he could move and that he would contact Ms Anderson to verify his claims regarding accommodation. Mr Plowright provided Jazzy with a written direction to attend his pre-organised appointment with his family doctor the following day on 26 March 2021 to obtain medication and for the preparation of a Mental Health Care Plan (MHCP).[22]

37. Importantly, at this attendance on 25 March 2021, Mr Plowright noted that Jazzy appeared to be suffering from a mental illness and appeared to be emotionally heightened.[23] Records note that Jazzy was directed to undertake, and complied with, a drug test which apparently returned a negative result.[24]

38. On 26 March 2021, Jazzy attended the GP Dr Sarath Wimalaratne, as arranged by his mother, who provided two referrals: the first was to Concord Repatriation General Hospital

[20] Vol 1, Tab 10, OIMS Case Notes, p220.
[21] Vol 1, Tab 10, OIMS Case Notes, p220.
[22] Vol 1, Tab 10, OIMS Case Notes, p222.
[23] Vol 1, Tab 10, OIMS Case Notes, p222.
[24] It is not clear whether this test was supervised.

Pain Management Clinic,[25] and the second to Dr Duygu Arslan of Welibe Psychology.[26] Dr Wimalaratne prepared a Mental Health plan (MHCP) dated 29 March 2019 which noted schizophrenia as the identified issue.[27]

39. On 29 and 30 March 2021, Jazzy reported at BCC to see Mr Plowright and he appeared calm and stable. Mr Plowright again indicated that a management plan must be in place and agreed to by his supervisors before Jazzy would be permitted to move. Ms Anderson from PSFNS confirmed her willingness to support the move with Temporary Accommodation (TA) and case management until she had organised long term accommodation.[28]

40. On 1 April 2021, Jazzy notified BCC that he had found accommodation from 4 April 2021 at the [redacted] in Raymond Terrace; accommodation at which he had resided prior to his most recent incarceration. Jazzy said Ms Anderson had helped to arrange the accommodation and he provided a signed letter from the General Manager of [redacted] confirming rent for the room on a weekly basis.[29] Mr Plowright called Ms Anderson the same day to confirm the accommodation as a "permanent weekly rental".

41. On 6 April 2021 Jazzy relocated to Raymond Terrace and his supervision on parole was immediately transferred from BCC to Maitland Community Corrections (MCC).

42. The next day, on 7 April 2021, Jazzy called Newcastle Community Corrections and informed them that he had no money to report on that date,[30] however the following day, 8 April 2021, he reported to MCC and records indicate that he engaged well and appeared motivated. At that appointment, Jazzy indicated that he had a MHCP from his doctor in Sydney but he still needed to attend a doctor in Newcastle for a local referral for psychology.[31] The records suggest that this was the first of only two in person attendances by Jazzy upon MCC. He was given a future appointment at MCC of 15 April 2021.

43. On 13 April 2021, Jazzy attended in person to see Ms Anderson at the PSFNS. He declined a referral to mental health supports stating that he had been given referrals from his doctor in Sydney. He also stated that he was reporting to MCC weekly.[32] This was Jazzy's only in person attendance with Ms Anderson.

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[25] Vol 2, Tab 11, Case History Notes, p103
[26] Vol 2, Tab 11, Case History Notes, p104.
[27] Vol 2, Tab 11, Case History Notes, p105.
[28] Vol 1, Tab 10, OIMS Case Notes, p223.
[29] Vol 1, Tab 10, OIMS Case Notes, p224.
[30] Vol 1, Tab 10, OIMS Case Notes, p225.
[31] Vol 1, Tab 10, OIMS Case Notes, p225.
[32] Vol 1, Tab 7, Statement of [redacted]; Vol 7, Tab 23, PSFANS File Notes, p2.

44. On 15 April 2021 Jazzy failed to attend an appointment at MCC and did not answer his phone when called.[33] He returned their call later that day and was told that his appointment was rescheduled for the following day.[34]

45. Jazzy attended the next day on 16 April 2021 and saw Colette Davies, a CCO who was not his designated CCO. Ms Davies recorded that Jazzy was exhibiting disordered thinking throughout the interview and that he reported a relapse on one occasion "the other day" when he used a small amount of ice.[35] Jazzy reported peer pressure and voices in his head telling him to take drugs. The records note that he had taken one of his prescribed mental health medications (Zyprexa) in the waiting room and that he took another during the interview.

46. On the same day, 16 April 2021, Jazzy's mother sent an SMS to Mr Plowright at BCC to advise that Jazzy was using drugs again. Mr Plowright's evidence was that he did not recall receiving this message as he may have been on annual leave and it was an employee mobile rather than his own. He also stated that if he had received the message, he would have contacted MCC to let them know about the SMS.[36] This was certainly a missed opportunity for information sharing. Employee mobiles, if unattended should be re-directed or have clear voice messages with redirection options available.

47. Six days later, on 20 April 2021, Jazzy did not attend his appointment with MCC as planned and did not answer his phone.[37]

48. Three days later, on 23 April 2021, Jazzy's designated CCO from MCC Morgan McCarter attended the [redacted] to look for Jazzy. He was informed that Jazzy was being evicted. The reasons given were a loud party on the first night that he stayed at the premises, followed by another loud party earlier in the week when Jazzy appeared to be under the influence of drugs and became verbally abusive and aggressive when security spoke to him. Mr McCarter knocked on Jazzy's door and his window but there was no answer, so he left the notice of eviction.[38] Ms Anderson at PSFNS was not advised that Jazzy was being evicted from the accommodation that she had helped arrange by either [redacted] or MCC.

49. It is noteworthy that on 24 April 2021 [redacted] informed Jazzy's mother that Jazzy "got ice again about 6am so I showered and left the motel. I'm gunna have lunch with my sister in

[33] Vol 1, Tab 10, OIMS Case Notes, p226.
[34] Vol 1, Tab 10, OIMS Case Notes, p226.
[35] Vol 1, Tab 10, OIMS Case Notes, p227.
[36] David Plowright, Transcript, 6 September 2023, p50.
[37] Vol 1, Tab 10, OIMS Case Notes, p227.
[38] Vol 1, Tab 10, OIMS Case Notes, p228.

Newcastle. He is mental right now. I can't stand being around him like that."[39] It was clear to family that things were deteriorating quickly.

50. Days later, on 28 April 2021, Jazzy telephoned MCC and apologised for not making earlier contact. Records indicate that he sounded well, engaged appropriately, and did not appear under the influence of any substances. He said he had been sleeping a lot. When challenged about the eviction notice, he denied aggression and he said that he had paid up his accommodation until 4 May 2021. He said that he had spoken to the Manager of [redacted] and could secure another week from that date to give him time to get alternative accommodation if necessary.[40]

51. In a statement prepared for this inquest, [redacted] recounts that Jazzy started to use ice and pot occasionally after his release to parole, and that Jazzy was using ice a couple of times a week until 28 April 2021 when he started using ice daily.[41]

52. On 2 May 2021, [redacted] called an ambulance to attend [redacted] where Jazzy was suffering from stomach cramps, vomiting and could not pass urine. He was taken by ambulance to John Hunter Hospital for treatment.

53. The following Monday, 3 May 2021, [redacted] telephoned MCC to inform them that Jazzy was in hospital after a three day ice binge and was now in an induced coma.

54. Jazzy died on 7 May 2021.

Post mortem examination

55. An external post mortem examination, including toxicological analysis was conducted on 11 May 2021. The report later produced recorded the cause of death as "complications of methylamphetamine use".

56. A review of the medical records found that he had been diagnosed with septicaemia, multi-organ failure, aspiration pneumonia, rhabdomyolysis, acidosis and severe shock which maximal medical management failed to arrest.

57. Toxicology detected amphetamine, methylamphetamine and cannabinoids. There is no dispute that his death was as a result of complications of methylamphetamine toxicity. There is also no evidence that his death was intentional, rather it occurred accidently in the context of an extended period of use.

The evidence of Community Corrections and Port Stephens Family Neighbourhood Service

[39] Vol 1, Tab 7, Statement of [redacted], [27].
[40] Vol 1, Tab 10, OIMS Case Notes, p228.
[41] Vol 1, Tab 8, Statement of [redacted] p2.

58. Mr Plowright, Jazzy's designated CCO upon his release, gave evidence that he had 20-30 clients on his caseload at the relevant time as well as team leader responsibilities. Professor Baldry gave evidence that this case load was too high for a case worker to support a complex needs client like Jazzy and that a maximum of 8-10 clients was ideal.[42]

59. Professor Baldry stated "the requirement that a community corrections officer manage/supervise dozens of clients (in David Plowright's case) many of whom have MHD &/or CD and ensure they comply with their MH plan, their medication, their housing arrangements, their abstinence from AOD and complete programs and attend all the appointments required is unrealistic" She noted that people with complex needs, like Jazzy had, should not be left to "criminal legal agencies" such as Community Corrections to manage, they should be case-managed in the community alongside any supervision a CCO may provide. I accept her opinion on this matter.

60. Jazzy had been released following an in custody RMP which assessed his Level of Service Inventory – Revised (LSI-R) to determine his risk of re-offending and to designate the level of service required to address the risk. The RMP must address risk factors related to the offender and their behaviour including any risks associated with the specific area or accommodation in which they propose to reside.[43] The RMP for Jazzy was conducted by the Parole Unit at Cessnock Correctional Centre on 17 February 2021 and Jazzy was determined to be tier 3/high which was the highest possible risk level and required once per week contact with the parolee and third parties and a home visit every four weeks[44] There was no requirement for an inspection of an address prior to release if the parolee had previously resided at the same premises, which was the case for Jazzy residing at his mother's home.[45]

61. The risk assessment in custody took into account both pro-social and risk factors. Jazzy's case was difficult as there were both pro-social and risk factors at both the proposed addresses in the Burwood and the Raymond Terrace area – a complication recognised by both Mr Plowright and Professor Baldry in evidence.[46] Professor Baldry gave evidence that the difficulty in assessment arose from the clear offending history in both places and the pro-social supports at both places, namely Jazzy's mother [redacted] and his partner [redacted], noting that the assessment of pro-social supports go beyond a consideration of the actual accommodation available.[47] Mr Plowright gave evidence that a residence that was deemed

[42] Professor Eileen Baldry, Transcript 16 November 2023, p39.
[43] Vol 7, Tab 24, Statement of David Plowright, Annexure C, p3, 7.1 "Risk mitigation plans".
[44] David Plowright, Transcript, 6 September 2023, p12-14; Vol 3, Tab 12e, D5.1 Service Delivery Standards for Supervised Offenders, p74; Vol 1, Tab 9jj, Risk Mitigation Plan, p163-173.
[45] David Plowright, Transcript, 6 September 2023, p26.
[46] David Plowright, Transcript, 6 September 2023, p48-49; Professor Eileen Baldry, Transcript, 16 November 2023, p37.
[47] Professor Eileen Baldry, Transcript, 16 November 2023, p37.

pro-social could change, which is what appeared to occur in relation to Jazzy shortly after he was released from custody.[48] Mr Plowright was specifically concerned about tension arising at the family home once Jazzy indicated that he didn't want to be there.

62. Mr Plowright gave evidence that Jazzy was adamant about leaving the Burwood area no matter what and as such it was the CCOs responsibility to ensure Jazzy did not re-offend or hurt anyone and that he continued to engage with the service no matter his location.[49]

63. Mr Plowright accepted that when Jazzy was residing in the Burwood area, his mother [redacted] was functioning as a *de facto* case manager, arranging doctor's appointments and culturally appropriate supports and encouraging Jazzy to attend his appointments. The level of assistance she provided was not something that BCC had the capacity to provide.[50] He also noted that there were no culturally appropriate post-release support workers in the Burwood area.[51]

64. Mr Plowright accepted that drug relapse allowed for a CCO to direct a parolee into rehabilitation, however waitlists made the issuing of such a direction unreasonable if the parolee could not comply due to a lack of availability.[52] He further noted a lack of services specific to ice residential rehabilitation, particularly in the immediate or short term.[53]

65. Mr Plowright gave evidence of the difficulty in engaging with [redacted] about the proposed move in circumstances where Jazzy was expressing distress at remaining. In his view this raised concerns that the risk of offending or harm to others might be escalated. Mr Plowright spoke of his knowledge of a prior incident at the Burwood premises and was keen not to place anyone in danger if tensions grew. In any event Mr Plowright said that a CCO had no right to refuse the transfer.[54]

66. Both Mr Plowright and Mr McCarter gave evidence that CC would not breach a parolee for disclosing a single relapse into drug use or for having a positive drug test (noting the drug test that was conducted on Jazzy was negative, but may have been unsupervised).[55] Rather, Community Corrections seeks to strike the right balance between policies that encourage the management of the situation in the community and the mitigation of risks in the community with automatic revocation and return to custody.[56] Part of this balance at

[48] David Plowright, Transcript, 6 September 2023, p30.
[49] David Plowright, Transcript, 6 September 2023, p46.
[50] David Plowright, Transcript, 6 September 2023, p15, 28.
[51] David Plowright, Transcript, 6 September 2023, p28.
[52] David Plowright, Transcript, 6 September 2023, p23; Morgan McCarter, Transcript, 7 September 2023, p20.
[53] David Plowright, Transcript, 6 September 2023, p27.
[54] David Plowright, Transcript, 6 September 2023, p48-49.
[55] David Plowright, Transcript, 6 September 2023, p44; Morgan McCarter, Transcript, 7 September 2023, p20, 26.
[56] David Plowright, Transcript, 6 September 2023, p18.

the commencement of a relationship between a parolee and a CCO is a focus upon building rapport.[57] Mr McCarter gave an example of managing a relapse in the community by the CCO attempting to accelerate a parolee's engagement in drug and alcohol counselling.[58]

67. Both Mr Plowright and Mr McCarter gave evidence that the State Parole Authority (SPA) had a preference for parolees to be managed in the community rather than moving to hasty breach action, especially if a parolee was remaining in contact with CC and exhibiting a willingness to keep engaging, as Jazzy was.[59] Ms Davies, the non-designated CCO who saw Jazzy at MCC, noted that SPA reports had to be focussed on the risk of re-offence rather than risk to the parolee.[60] It was an important point to make clear and in my view emphasises the need for the involvement of an independent support worker in these circumstances whose focus is on the therapeutic and social needs of the parolee, rather than on the risk of re-offence. These risks may overlap, but they remain distinct.

68. Mr McCarter gave evidence that, as an Aboriginal man himself, "my brothers don't need to go to gaol more." Mr McCarter further stated that, having worked in prisons, the decision to breach a parolee and return them to custody was a weighty decision and that if Jazzy had returned to custody he would have been released at the end of his sentence with no supervision on parole. [61]

69. CC Policy did not require that a further RMP be conducted before Jazzy was permitted to move from Burwood to Raymond Terrace as the LSI-R done in custody was still valid.[62] The policy referred to a "significant change" that would warrant the re-application of the LSI-R but Mr Plowright did not consider the change of address from Burwood to Raymond Terrace as a significant change given that the address constituted only one or two points in the LSI-R and did not greatly affect the end level of risk calculated. It is important to remember that even if a further risk assessment had been conducted, there was no higher risk level to which Jazzy could have been elevated.[63] He was already receiving the most intensive supervision available in the circumstances.

70. In assessing the risks associated with the move, it was the role of the receiving office, MCC, to update the case plan to include relevant information relating to third parties including family and treatment providers.[64] Mr McCarter gave evidence that the RMP conducted in

[57] Morgan McCarter, Transcript, 7 September 2023, p26-27.
[58] Morgan McCarter, Transcript, 7 September 2023, p20.
[59] David Plowright, Transcript, 6 September 2023, p54; Morgan McCarter, Transcript, 7 September 2023, p26.
[60] Collette Davies, Transcript 7 September 2023, p47.
[61] Morgan McCarter, Transcript, 7 September 2023, p27.
[62] Vol 3, Tab 12a, p4, D2 Assessment Policy 2.2.2. "Ongoing Assessment"; Vol 3, Tab 12g, D7 "Transfers between offices".
[63] David Plowright, Transcript, 6 September 2023, p21-22.
[64] David Plowright, Transcript, 6 September 2023, p23.

custody would be expected to be reflected in the case plan already completed by BCC and the plan subsequently done by MCC and no changes of significance would be expected across those documents.[65]

71. Prior to the move, it was the responsibility of the transferring office, BCC, to ensure all assessments and case management plans were up to date and this was done.[66] With regard to the OIMS record "conduct review of breakdown of post-release plan", Mr Plowright confirmed that this referred to an intention of BCC to work out why the plan to release Jazzy to his mother's home had broken down in such a short period. He stated that this was not a formal process and may have just involved discussions with Jazzy and third parties.[67] As noted above, the evidence of Professor Baldry was that it is common for parolees to be released to their parental home and in more than half of those cases the arrangement breaks down shortly after release and the parolee seeks to relocate.[68]There is little doubt that the period just after release is a particularly stressful time.

72. Mr Plowright gave evidence that he could not think of any circumstance in which a CCO was authorised to refuse a transfer as it was always better for a parolee to have some supervision rather than none at all.[69] For example, a transfer cannot be refused due to outstanding assessments or tasks, nor can it be refused if the parolee changes address without permission.[70] The role of a CCO is to prioritise community safety and to ensure that offences are not committed by making sure the parolee is supervised regardless of any outstanding tasks or even an unauthorised move.[71] The aim is to remain in contact. Mr Plowright gave evidence that his main concern was that Jazzy may move without permission and lose contact with Community Corrections altogether.[72]

73. Mr Plowright accepted that the fragmentation of services provided between CCOs, community organisations such as PSFNS, and housing providers such as [redacted] is not ideal. There can be a lack of consistent communication and universal policies, as well as problems caused by the need for individual consents across different organisations to provide for proper information sharing.[73] Better communication between CCOs and organisations such as PSFNS would be ideal as Mr Plowright stated that he understood Ms Anderson at PSFNS would be taking on a role similar to that [redacted] had undertaken in Burwood including

[65] Morgan McCarter, Transcript, 7 September 2023, p29.
[66] David Plowright, Transcript, 6 September 2023, p31; Vol 3, Tab 12g, D7 Transfers between Offices, 7.2 and 7.3, p95-96; Exhibit 3, Burwood CC case plan for Jazzy dated 12 March 2021.
[67] David Plowright, Transcript, 6 September 2023, p42.
[68] Professor Eileen Baldry, Transcript, 16 November 2023, p37-38.
[69] David Plowright, Transcript, 6 September 2023, p35.
[70] Vol 3, Tab 12g, D7 Transfers between Offices, p97-98; David Plowright, Transcript, 6 September 2023, p34-35.
[71] David Plowright, Transcript, 6 September 2023, p22, 34-35.
[72] David Plowright, Transcript, 6 September 2023, p48-49.
[73] David Plowright, Transcript, 6 September 2023, p38.

arranging doctor's appointments and drug treatment. While Ms Anderson gave evidence that her involvement was minimal and that she understood that MCC would be arranging these things.[74]

74. Mr Plowright welcomed more training in mental health for CCOs,[75] as well as endorsing the Ice Inquiry recommendations 99 and 102 regarding dedicated case management, safe and stable housing, primary and mental health services, drug treatment on a health needs basis as measures that would have helped Jazzy and which CC was not presently resourced to provide.[76]

75. Ms Anderson, a Senior Practitioner from PSFNS, gave evidence about the assistance she provided to Jazzy in obtaining accommodation at [redacted] She said [redacted] provided two types of accommodation, one being TA that the Department of Housing utilise and another being a weekly rate for more permanent accommodation. In April 2021 Jazzy went to [redacted] under the second type of accommodation, namely the weekly more permanent rate which, according to Ms Anderson, had no involvement with the Department of Housing or any agency receiving funding from them. Jazzy had been offered that arrangement in 2021 due to being housed there via the Link2home service the previous year.[77] [redacted] the Manager of [redacted] gave evidence confirming that, whilst he could not recall details of the arrangement with Jazzy upon his second stay at [redacted], if a person had previously stayed as a Housing client then they may be permitted to stay again as a weekly rental client.[78] Ms Anderson gave evidence that there were people that she was aware of who had been living at [redacted] on the more permanent rate for over two years.[79]

76. Ms Anderson had a caseload of around 10 clients at any one time, and she was also tasked with overseeing 7 case workers. All her clients would fall into the category of complex support needs like Jazzy including having mental health issues, brain injury and substance use issues.[80]

77. Ms Anderson's service was not mandated and as such, whilst she could offer and recommend assistance to clients, she could not pursue them to enforce compliance.[81] CCOs would take on that role, however PSFNS could not inform MCC that a parolee was not attending treatment as suggested unless the parolee had consented to such disclosure

[74] David Plowright, Transcript, 6 September 2023, p45.
[75] David Plowright, Transcript, 6 September 2023, p52.
[76] David Plowright, Transcript, 6 September 2023, p52.
[77] Kylee Anderson, Transcript, 6 September 2023, p62-63.
[78] [redacted] Transcript, 16 November 23, p7-8.
[79] Kylee Anderson, Transcript, 6 September 2023, p63.
[80] Kylee Anderson, Transcript, 6 September 2023, p64.
[81] Kylee Anderson, Transcript, 6 September 2023, p64.

which Jazzy had not yet done.[82] Ms Anderson had assumed in 2021 that MCC was arranging mental health and drug and alcohol services for Jazzy when he arrived in Raymond Terrace.[83] She told the court that it was not PSFNS's responsibility to take clients to appointments, however if a client requested the service, she would have been happy to assist.[84] I accept PSFNS had a limited role in assisting Jazzy get his own accommodation on this occasion and that the organisation had no further obligations.

78. PSFNS is not bound by any of the polices of CC and there was no Memorandum of Understanding (MOU) between MCC and PSFNS in 2021, nor was there clear communication. Both Ms Anderson and Mr McCarter welcomed better communication and an MOU between the two organisations, accepting that consent issues restrict the flow of information from MCC to PSFNS and [redacted].[85] The court was informed that some improvement in communication has occurred in the local area in the last six months due to a regular Monday Hub meeting at [redacted] attended by both MCC and PSFNS.[86] Ms Lane, the current manager of MCC saw no impediment to formalising an MOU for better communication and collaboration between PSFNS and MCC.[87] Consent as to informing TA providers about the clients staying at the premises was an issue acknowledged by the Department of Housing.[88]

79. When Ms Anderson spoke to and saw Jazzy in 2021, he appeared mentally stable. He told her about the doctors that he had been referred to by his Sydney GP and she did not detect any signs of drug or alcohol use.[89] However, if she had seen a decline in his mental health or indications of drug use there were few options available for referral and waiting lists were high. There was one local Salvation Army drug and alcohol counsellor, and residential rehabilitation was only available in Newcastle, Belmont, the Central Coast or Cessnock but each had extended waiting lists. Both Ms Anderson and Mr McCarter stated that there had been no real improvements seen in their area since Jazzy's death or since the Ice Inquiry".[90]

80. Ms Anderson was never advised that Jazzy had received an eviction notice from [redacted] and would welcome a protocol for this type of information sharing between accommodation providers, PSFNS and MCC.[91]

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[82] Kylee Anderson, Transcript, 6 September 2023, p65.
[83] Kylee Anderson, Transcript, 6 September 2023, p67.
[84] Kylee Anderson, Transcript, 6 September 2023, p68.
[85] Kylee Anderson, Transcript, 6 September 2023, p65-66; Morgan McCarter, Transcript, 7 September 2023, p16; [redacted] Transcript 16 November 2023, p17.
[86] Kylee Anderson, Transcript, 6 September 2023, p67.
[87] Louise Lane, Transcript 7 September 2023, p55.
[88] Wilma Falcone, Transcript, 16 November 2023, p25-26.
[89] Kylee Anderson, Transcript, 6 September 2023, p69-70.
[90] Kylee Anderson, Transcript, 6 September 2023, p71; Morgan McCarter, Transcript, 7 September 2023, p22.
[91] Kylee Anderson, Transcript, 6 September 2023, p72.

81. Mr McCarter was Jazzy's designated CCO at MCC, however he never met Jazzy and only spoke to him over the phone on one occasion on 28 April 2021.[92] Jazzy was seen by other MCC CCOs, namely Mr Kowalski and Ms Davies. In fact, OIMs records show that Jazzy saw or spoke to different officers each time he was in contact with MCC. Both Mr McCarter and Ms Davies accepted that best practice would be to have continuity for a parolee especially one with complex support needs like Jazzy. Mr McCarter noted that at times Jazzy reported to the office outside his allotted reporting appointments and that the practice at MCC was not to turn parolees away if their CCO was unavailable but rather to have the parolee seen by another CCO. Ms Davies gave evidence that in her view parolees who turned up outside allotted appointments should be redirected to report when their designated CCO was available.[93] There may be benefits of each approach.

82. Mr McCarter stated that his practice prior to the first appointment with a parolee as designated CCO was to review the case plan from the prior office and consider the referral services available and appropriate for the parolee, as well as gaining consent to contact the GP to substantiate appointments and referrals. The records show that the case plan for Jazzy from BCC was allocated to Mr McCarter on 26 April 2021, but Mr McCarter had not updated the case plan as there had not been enough time with Jazzy to properly commence the process of engagement.[94] Mr McCarter told the court that he would have embraced contact with Jazzy's mother [redacted] if he had consent from Jazzy to do so.[95]

83. Mr McCarter gave evidence (consistent with that of Mr Plowright) that a CCO's role was not to tell a parolee that they could not live at a certain address, but rather to assist them in managing the environment they were in.[96] In any event, [redacted] was the only option available in the area at the time for people who were homeless or transient[97] and Jazzy was unable to reside with [redacted] due to the terms of the AVO.

84. Mr McCarter was unaware of Jazzy's impending eviction from [redacted] until he attended the premises in person and was advised by the manager. If Jazzy had been at the premises at the time, then Mr McCarter's evidence is that he would have supported him to resolve the issue with the manager.[98]

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[92] Morgan McCarter, Transcript, 7 September 2023, p7, 16.
[93] Morgan McCarter, Transcript, 7 September 2023, p6; Collette Davies, Transcript, 7 September 2023, p43-45.
[94] NSW Dept of Corrective Services Maitland Offender Case Plan, Exhibit 6; Morgan McCarter, Transcript, 7 September 2023, p24-25.
[95] Morgan McCarter, Transcript, 7 September 2023, p17-19.
[96] Morgan McCarter, Transcript, 7 September 2023, p11, 30-31.
[97] Morgan McCarter, Transcript, 7 September 2023, p12-13, 31.
[98] Morgan McCarter, Transcript, 7 September 2023, p13.

85. Ms Lane, the manager of MCC, gave evidence about some potential, possibly more appropriate options for Jazzy. Jazzy would have been eligible for referral by his CCO to the Initial Transitional Support (ITS) worker Housing Plus, however there were only 12 places in the Maitland, Cessnock and the Raymond Terrace area.[99] As for the Transitional Supported Accommodation (TSA) service, which provided a specific caseworker support program, there was one house in Newcastle with only five beds available servicing the Raymond Terrace area.[100] Services such as the Extended Reintegration Service (ERS) were not available to Jazzy as they were only available to those in the Southwestern Sydney area.[101]

86. Mr McCarter and Ms Lane's evidence (consistent with that of Ms Anderson) was that there were also extremely limited services in the Raymond Terrace area in terms of drug treatment, attending a local GP for a mental health care plan and there were no culturally appropriate services.[102] Mr McCarter had assumed it would be his role as the designated CCO to arrange referrals and would not have assumed that PSFNS was undertaking those tasks, but he had not had enough time with Jazzy to make such arrangements.[103]

87. Mr McCarter agreed with Ms Anderson regarding the difficulties of consent for communication between organisations and noted that best practice was to obtain a signed consent from the client as soon as the other service provider was identified.[104]

88. Mr McCarter gave evidence that the decision about how to deal with an admission of substance use was the responsibility of the designated CCO and not another CCO who may have seen the parolee due to their attendance outside a scheduled appointment. He stated that the non-designated case officer would not be in a position to weigh the entirety of the situation.[105] Mr McCarter gave evidence that if Jazzy had been present when Mr McCarter attended at [redacted] and found out about the eviction notice, he would have accelerated efforts to get Jazzy into the Mental Health and Substance Use Service at the Mater Hospital in Waratah, in light of Jazzy's recent admission of drug use. However, the reality of waitlists would have meant that Jazzy was not engaged for at least a number of weeks.[106] In my view the lack of support for those struggling with mental health issues and ice addiction needs to be addressed. The fact that the court heard that the situation on the

[99] Louise Lane, Transcript 7 September 2023, p87-88.
[100] Louise Lane, Transcript 7 September 2023, p59-60.
[101] Louise Lane, Transcript 7 September 2023, p60.
[102] Morgan McCarter, Transcript, 7 September 2023, p11; Louise Lane, Transcript 7 September 2023, p55.
[103] Morgan McCarter, Transcript, 7 September 2023, p16-17.
[104] Morgan McCarter, Transcript, 7 September 2023, p15.
[105] Morgan McCarter, Transcript, 7 September 2023, p21.
[106] Morgan McCarter, Transcript, 7 September 2023, p21-22.

ground does not feel improved after the very important work completed by the Ice Inquiry is of significant concern.[107]

89. Ms Davies, the non-designated CCO at MCC who saw Jazzy when he reported in person on 16 April 2021 gave evidence that he appeared to have disordered thinking and that he told her that he heard voices telling him to take drugs and that he had taken a small amount of ice "the other day". Ms Davies gave evidence that she did not deem it necessary to take any action at that time as he appeared stable, was medicated for his mental health issues and he had reported drug use on one occasion only. She also stated that she was not the most appropriate person to determine what action should occur as she was not Jazzy's designated CCO.[108] Further, the policy regarding directions for drug testing note that a direction is not appropriate if an offender admits use and test results would not change the CCO's response.[109] Applied to Jazzy, the response if a drug test had returned a positive result would have been the same, that is to continue to manage him in the community and support him to remain drug free. Mr McCarter had intended to assist him to do this when he met with Jazzy, but unfortunately Jazzy did not attend his appointment and the follow up by Mr McCarter at [redacted] did not result in a face-to-face meeting with Jazzy.

90. I note for completeness that Covid-19 measures were in place for some of the relevant period. This may have impacted the service delivery to Jazzy from time to time, including affecting the availability of Jazzy's designated CCO at MCC when he attended outside scheduled appointments.[110]

91. Neither Mr Plowright nor Mr McCarter considered electronic monitoring appropriate for Jazzy.[111] I accept their view. Mr McCarter gave evidence that electronic monitoring was not something considered lightly by a CCO and would require a clear reason. Mr McCarter gave the example of the need to monitor a parolee pursuant to an AVO or a parolee which the SPA had specifically directed must be subject to electronic monitoring.[112]

Evidence of Department of Community and Justice on accommodation

92. One of the clear difficulties facing Jazzy on his release from custody was his need for supported accommodation. While his mother was always open to providing Jazzy with a supportive home, once he decided to leave that accommodation, Jazzy was in a precarious

[107] Kylee Anderson, Transcript, 6 September 2023, p71; Morgan McCarter, Transcript, 7 September 2023, p22.
[108] Collette Davies, Transcript, 7 September 2023, p39-40.
[109] Collette Davies, Transcript, 7 September 2023, p42; Vol 3, Tab 12i, p114 "Policy E2 Drug Testing 2.2.2".
[110] See for eg Morgan McCarter, Transcript, 7 September 2023, p9; Collette Davies, Transcript, 7 September 2023, p38; Louise Lane, Transcript, 7 September 2023, p51-52; Exhibit 7, MCC Stage 3 Covid roster.
[111] David Plowright, Transcript, 6 September 2023, p29; Morgan McCarter, Transcript, 7 September 2023, p19-20.
[112] Morgan McCarter, Transcript, 7 September 2023, p19-20.

and dangerous situation which was always going to place him at significant risk. Prior to assessing the accommodation resources and options that may have been available for CC officers to offer Jazzy, it was necessary to grapple with the operation of the public and social housing landscape in NSW. The evidence provided established that the sector is both fragmented, difficult to navigate and under-resourced.

93. The court was informed that The Department of Communities and Justice – Housing ("DCJ") provides, and works with service agency partners and individuals to provide, a range of housing solutions for the private rental market and social housing.[113] Social housing refers to long-term housing assistance whereby DCJ provides secure and affordable rental housing for people on low incomes with housing needs, including those exiting or who have recently exited custody.[114] Social housing incorporates Public Housing, Community Housing and Aboriginal Housing.[115] The Land and Housing Corporation ("LAHC") own properties used for social housing[116] and DCJ is responsible for the management of these properties for Public Housing. DCJ also fund Community Housing Providers ("CHPs") to manage Community Housing in specific areas. [117] DCJ or CHPs can manage Aboriginal Housing.[118]

94. DCJ oversees the Housing, Disability, District Services and Disaster Welfare ("HDDSDW") as well as the Strategy, Policy and Commissioning ("SPC").[119] HDDSDW oversees Housing Statewide Services ("HSS") and the Housing Contact Centre ("HCC"). Link2Home, a housing service delivered directly to clients, is delivered by HCC.[120] SPC oversees Housing, Homelessness, Disability and Seniors (incorporating Homelessness Programs and the Community Housing Branch) as well as FACS Insights, Analysis and Research.[121] Of note, HSS is responsible for overseeing DCJ housing policies and procedures across NSW.[122]

95. It was immediately clear that there was no simple housing solution for Jazzy. Securing long term public housing is a near impossible dream for someone in Jazzy's situation. The court was informed DCJ's Housing Pathways is the overarching framework which informs how applications for housing assistance are managed in NSW. Housing assistance through

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[113] NSW Government, DCJ Housing, 5 September 2023, found: https://www.service.nsw.gov.au/nswgovdirectory/dcj-housing
[114] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [6]; Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [8].
[115] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [8]; NSW Government, DCJ Housing, 5 September 2023, found: https://www.service.nsw.gov.au/nswgovdirectory/dcj-housing
[116] Wilma Falcone, Transcript, 16 November 2023, p24.
[117] Ibid p25.
[118] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [6].
[119] DCJ Housing Related Witnesses Organisational Structure.
[120] Ibid; Wilma Falcone, Transcript, 16 November 2023, p20.
[121] DCJ Housing Related Witnesses Organisational Structure.
[122] Wilma Falcone, Transcript, 16 November 2023, p20; Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [3].

Housing Pathways includes providing co-ordinated information about housing assistance, a standard assessment process and a single waiting list, namely the NSW Housing Register.[123] This register lists applicants in order according to their required housing location, approval category and approval date.[124] Further, it is segmented into priority and general categories which determines housing allocation.[125]

96. Clients, including clients who are in custody or who have recently been released can apply for social housing through the Housing Pathways application process.[126] If they are eligible, they are placed on the NSW Housing Register until a property becomes available.[127] It is noted that wait times for such properties are lengthy. For example, in Raymond Terrace, the expected wait time for a studio/1-bedroom apartment is 10+ years.[128] The kind of wait time involved meant that it was of little relevance to Jazzy. There is a clear and pressing need for more public housing.

97. Given the appalling shortage of public housing for those in need, Government provides a patchwork of stop gap measures. It is beyond the scope of these reasons to assess each option or set out in detail the fragmented approach that has developed in lieu of providing a comprehensive solution to homelessness in NSW.

98. The court received evidence about a variety of programs which DCJ offers in partnership with CHPs[129]or which it funds non-government organisations to provide. The court was informed that the Specialist Homelessness Services ("SHS") program is the NSW Government's primary response to homelessness.[130] DCJ, and the Australian Government as a co-contributor, [131] fund non-government organisations ("SHS providers"),[132] currently until 30 June 2024,[133] to deliver a range of services to support individuals who are homeless or at risk of becoming homeless,[134] including individuals who have recently been released from custody or who have previously exited custody.[135] This program is managed by DCJ's

[123] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [4]-[5].
[124] Ibid [26].
[125] Ibid [26].
[126] Ibid [23].
[127] Ibid [24].
[128] NSW Government Communities & Justice, 'Expected waiting times', 17 December 2020 <https://www.facs.nsw.gov.au/housing/help/applying-assistance/expected-waiting-times>
[129] See for example Exhibit 12, Together Home Program as discussed in the statement of Humair Ahmad, [10]
[130] Vol 7, Tab 28, Statement of Matthew Barden, [6].
[131] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, [11].
[132] Vol 7, Tab 28, Statement of Matthew Barden, 19 June 2023, [3].
[133] Ibid [6].
[134] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, [3].
[135] Vol 7, Tab 28, Statement of Matthew Barden, 19 June 2023, [3], [5]; Exhibit 12, Statement of Humair Ahmad, 15 November 2023, p105; Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [3].

Strategy, Policy and Commissioning who report to DCJ Housing and Homelessness Strategy Steering Committee.[136]

99. An individual may access the SHS program through a variety of pathways such as through a referral from Link2Home, the Domestic Violence line, a team using an assertive outreach approach, DCJ[137] or a SHMT CHP.[138] The SHS program can also be accessed through self-referral, or an individual may be referred by a third party.[139]

100. An individual is eligible for the SHS program if they are homeless or at risk of homelessness. An individual is 'homeless' if they are living in non-conventional accommodation such as living on the streets, or they are living in short-term or emergency accommodation such as in refuges or they are couch surfing.[140] An individual is at 'risk of homelessness' if they are at risk of losing their accommodation due to a range of factors such as financial stress, mental health issues and family or relationship breakdown.[141]

101. On that definition one would think Jazzy was eligible.

102. An individual may not be eligible for a specific SHS provider they accessed as SHS providers may have a specific delivery model and target client group(s).[142] For example, some SHS providers, such as Getting Out Finding Home and Glebe House Homelessness Support Service for Men Exiting Custody, focus specifically on assisting clients who are experiencing a risk of homelessness upon exiting custody.[143] However, the SHS program employs a 'No Wrong Door' approach meaning an individual will receive or be assisted to receive support wherever they access an SHS service provider.[144]

103. If DCJ is unable to refer clients to the SHS program, they may refer clients to another service such as Link2Home or refer them to their local DCJ Housing Office to secure TA[145] such as in a hotel and motel.[146] It is noted that a client remains eligible for SHS accommodation and support services irrespective of the amount of TA they have received.[147]

104. It appears clear that some of the services offered by SHS providers or through the Reintegration Housing Support Program (RHSP) are positive initiatives. It was reported that

[136] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, p41.
[137] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [14].
[138] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, p26-27.
[139] Ibid p26-27.
[140] Vol 7, Tab 29A, Definition by the Australian Institute of Health and Welfare – Second Statement of Matthew Barden, 28 August 2023, p21.
[141] Ibid p22.
[142] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, p21.
[143] Vol 7, Tab 28, Statement of Matthew Barden, 19 June 2023, [4].
[144] Ibid [4]; Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, p27.
[145] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [4]; Vol 7, tab 29A, Second Statement of Matthew Barden, 28 August 2023, [7].
[146] Wilma Falcone, Transcript, 16 November 2023, p22.
[147] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, [13].

531 SHS clients leaving custody in the 2021-2022 reporting year were provided with SHS accommodation[148]. The court heard a little about the service offered by the Community Restorative Centre (CRC) through this program. The Reintegration Housing Support Program ("RHSP") is delivered by the Community Restorative Centre ("CRC") to provide wrap-around psychosocial support to individuals leaving custody who are at risk of homelessness.[149] The program connects its clients with in-reach services prior to their release and immediately following their release from custody and aims to improve their wellbeing, long term housing and reduce recidivism.[150] This program provides three months pre-release support and nine months post release support for inmates who are over 18, at risk of homelessness upon exiting custody, have a mental health or cognitive problem, issues with alcohol and drugs and are on a community correction order.[151]

105. The RHSP was initially launched in July 2021[152] and is a partnership between Community Corrections, NSW Health and Link2Home.[153] The CRC is funded by DCJ's Strategic Policy and Commissioning[154] to provide case management for up to 20 clients per year[155] until 30 June 2024.[156] The RHSP currently operates in six locations across NSW,[157] with two CRC support workers based in each of the following DCJ Housing Offices: Inner Sydney, Western Sydney, South-Western Sydney, Western NSW, Illawarra and the Hunter area.[158] As at August 2023, 517 clients had been supported through the RHSP, including 103 active clients and 414 who had exited the program.[159] The RHSP has been recognised as a "very successful program because it's that hands on support."[160] From what I have seen the program should be supported and enlarged.

106. Mr Nelson Tilbrook, Manager Strategic Partnerships Directorate, Corrective Services NSW, gave further evidence regarding the contracting of non-government organisations to provide services and programs for Corrective Services clients in custody and the community, as well as the relationship between Corrective Services and the Department of Housing to ensure their mutual clients have access to good housing outcomes.[161]

[148] Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, [11].
[149] Email from Wilma Falcone, Information regarding RHS Program, 16 November 2023, p1.
[150] Ibid.
[151] Nelson Tilbrook, Transcript, 7 September 2023, p66.
[152] Email from Wilma Falcone, Information regarding RHS Program, 16 November 2023, p1.
[153] Nelson Tilbrook, Transcript, 7 September 2023, p66.
[154] Wilma Falcone, Transcript, 16 November 2023, p31-32.
[155] Nelson Tilbrook, Transcript, 7 September 2023, p66.
[156] Email from Wilma Falcone, Information regarding RHS Program, 16 November 2023, p1.
[157] Wilma Falcone, Transcript, 16 November 2023, p31-32.
[158] Email from Wilma Falcone, Information regarding RHS Program, 16 November 2023, p1.
[159] Email from Wilma Falcone, Information regarding RHS Program, 16 November 2023, p1-2.
[160] Wilma Falcone, Transcript, 16 November 2023, p31-32.
[161] Nelson Tilbrook, Transcript, 7 September 2023, p63.

107. Mr Tilbrook gave evidence that the TSA program provided a 12 week supported accommodation after release plan but unfortunately the demand exceeded the supply of only 30 beds in the whole of NSW with no plan for further roll-out, and only 8 of those beds were available in Newcastle and Wyong servicing the Raymond Terrace area.[162] Whilst TSA was typically reserved for people exiting custody, if there was a vacancy and a parolee was experiencing homelessness or at risk of same, they could be referred to the program.[163] The TSA program provides up to 12 weeks of supported accommodation and case work support to medium-high / high risk people following their release from custody. Service providers are contracted to support up to 120 people per annum with 30 beds across NSW.[164]

108. Mr Tilbrook gave evidence that the ERS program provided a 12 month support program which consisted of 3 months pre-release support and nine months post. Eligibility requirements included a risk of homelessness upon exiting custody, mental health or cognitive impairment as well as alcohol and drug issues. Unfortunately, the capacity is only 20 clients per year and is limited to Southwest Sydney (Fairfield, Liverpool, Bankstown, Campbelltown and Camden) as operated by the Community Restorative Centre (CRC), a non-government organisation.[165]

109. In November 2023, NSW Health announced a new Post Custodial Support (**PCS**) program funded as part of the NSW Government response to the Ice Inquiry. The PCS will provide intensive and comprehensive treatment and support for people leaving custody who have a history or risk of harmful drug and alcohol use. Assessment and care planning will begin up to 3 months before the person's release from custody and continue for us to 12 months post-release[166]. While it is too early to assess the efficacy of such an initiative, its introduction is strongly supported.

110. DCJ submitted that at first instance it will seek to refer a client experiencing homelessness or at risk of homelessness to a SHS and in circumstances where a SHS is not available a client may be referred to TA. I accept that but given the capacity of these kinds of specialist programs, there appears in practise to be an over-reliance on temporary accommodation for those exiting custody who are at risk of homelessness.

111. Temporary accommodation ("TA") refers to short-term accommodation[167] in low-cost motels or caravan parks[168] provided to individuals who are homeless or at risk of homelessness,

[162] Nelson Tilbrook, Transcript, 7 September 2023, p63-64.
[163] Nelson Tilbrook, Transcript, 7 September 2023, p65.
[164] Nelson Tilbrook, Transcript, 7 September 2023, p63.
[165] Nelson Tilbrook, Transcript, 7 September 2023, p66-67.
[166] Nelson Tilbrook, Transcript, 7 September 2023, p60-61, 66.
[167] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [4].
[168] Ibid [4].

who have secured a housing solution but are temporarily homeless or who are in a DCJ or CHP managed property but are unable to stay in the property.[169]

112. TA is provided by commercial operators which are paid on a fee for service basis.[170] DCJ Housing is effectively a user of a commercial accommodation facility.

113. The court was informed that the provision of TA serves as a bridge between accommodation[171] to give individuals a chance to secure alternative longer term accommodation, whether that be crisis accommodation or a private rental,[172] or to seek support from SHS providers.[173] There is no specific waiting list for clients to receive assistance to access TA.[174]

114. Clearly TA is no longer just a "bridge", for some disadvantaged clients it is a negative and extended holding pattern. Previously, TA could not be provided for more than 28 days in a 12-month period other than in exceptional circumstances.[175] However, this cap was removed on 12 July 2023.[176] Other changes regarding TA eligibility included an increase in the 'cash asset' limit from $1,000 to $5,000 and the removal of a cash asset limit for individuals escaping domestic and family violence. [177] Further, clients are no longer required to contribute to the cost of TA.[178] DCJ Housing frontline staff were notified of these changes by the Housing Pathways Notice issued on 13 July 2023.[179] While I see the clear need to remove the cap and introduce these changes, I have no doubt this will also mean many of our disadvantaged community members are left for months in motel and other sub-standard accommodation.

115. The court was informed that DCJ uses over 300 TA providers across NSW.[180] As of 7 November 2023 there were 323 TA providers across NSW of which 226 were classified as motels/hotels. The court was informed that in 2022-2023, 26 149 households were assisted with TA. Many of these would be living in motels or hotels for extended periods.

[169] Manage Inspections of Temporary Accommodation Properties, p1.
[170] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023 [11].
[171] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, p35.
[172] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [4].
[173] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [18].
[174] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [10].
[175] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [4].
[176] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [12].
[177] Ibid.
[178] Ibid.
[179] Ibid.
[180] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [11].

116. DCJ also reported that often TA options are limited in specific locations due to costs being prohibitive or due to service providers not wishing to conduct business with DCJ as a result of negative experiences with former DCJ clients.[181]

117. Following initial TA being provided to a client, that client is required to attend a DCJ Housing or CHP office to complete a housing needs assessment, upon which, if necessary, staff will assist the client to find longer term accommodation.[182] An extension of TA for a client may be declined if they do not meet certain responsibilities such as abiding by the rules of the accommodation facility or not leaving the accommodation in good order.[183] TA providers are also expected to advise DCJ Housing if a client does not attend their premises, engages in antisocial or illegal behaviour or if client causes damage to premises.[184]

118. It is important to note that when Jazzy made the decision to move from his mother's home, he ended up in accommodation that he had *previously* been given as a TA option. However on this occasion he obtained the housing himself through his former caseworker.

119. TA in motels and caravan parks is often provided to clients by independent[185] commercial operators. [186] DCJ and CHP have a commercial relationship with such providers and pay for TA on a fee for service basis or at a nightly rate.[187] However, at times DCJ Housing or a CHP may negotiate TA for longer periods for clients at a reduced cost.[188] In Jazzy's case he appears to have gone to a previous caseworker and they used their ongoing relationship with a TA provider to get him accommodation quickly as a private arrangement.

120. The court heard that DCJ Housing Offices and CHPs are front line, client facing offices across NSW. Staff in these offices assist clients with their housing needs including extensions for temporary accommodation ("TA") placements, preparing TA case plans, following up on referrals sent to Specialist Homelessness Services ("SHS") & non-SHS providers and assisting clients with NSW Housing products such as housing applications, rental subsidies and bond loan applications.[189]

121. The Community Housing Branch is comprised of 30 staff members who are responsible for managing relationships between DCJ and approximately 80 Community Housing Providers

[181] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [11].
[182] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [19].
[183] See Vol 7, Tab 29D, Part 3.6 of the Rentstart Assistance Policy, Second Statement of Wilma Falcone, 30 August 2023, [15]-[17].
[184] Vol 7, Tab 29D, Second Statement of Wilma Falcone, 30 August 2023, [39].
[185] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [18].
[186] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [11]; Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [18]; Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [16].
[187] Vol 7, Tab 29, First Statement of Wilma Falcone, 27 June 2023, [11]; Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [18]; Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [16].
[188] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [21].
[189] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [7].

in Social Management Transfer areas ("SHMT CHPs") including overseeing contracts between them, managing funding and overseeing the delivery of other DCJ programs delivered by CHPs.[190] This branch serves as a direct contact for CHPs in relation to DCJ related matters including dealing with all community housing related correspondence and the handling of complaints.[191] The Community Housing Branch meet with SHMT CHPs quarterly as a group to discuss issues as they arise and provides updates of DCJ business such as new or changes to existing products, policies or procedures related to the delivery of housing services.[192]

122. DCJ transferred the tenancy management of approximately 14,000 social housing tenancies, including the delivery of private rental assistance products, to Community Housing Providers ("CHPS") under Housing Pathways.[193] As such, CHPs in Social Management Transfer areas ("SHMT CHPs") are now contracted by DCJ to deliver all housing services, both Private Rental Assistance and social housing products, in their specific area. There are nine SHMTs which are essentially designated areas where a CHP delivers local housing services previously provided by DCJ Housing.[194] Evidently, in SHMT areas, DCJ Housing no longer deliver any services.[195] As a result of this transfer in tenancy management, CHPs are now responsible for the management of around 50,000 properties for very low to moderate income households and further, they deliver 34% of housing in NSW.[196]

123. CHPs are responsible for delivering the Community Housing Leasing Program which has been in operation since 2000 and is apparently designed to give CHPs increased flexibility in accommodating eligible people in housing[197] such as by allowing CHPs to increase or decrease their supply by location, source suitable property types and/or other factors to respond to the needs and priorities of clients.[198] CHPs are engaged to head lease properties in the private rental market and house individuals who are currently street sleeping or have a history of street sleeping.[199] Some CHPs engage with and sub-contract support providers such as Specialist Homelessness Services ("SHS") to ensure they deliver wrap-around support tailored to the client's particular needs.[200] If so, CHPs need to seek approval from DCJ for each support provider and the delivery model employed.[201] CHPS are also required

[190] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [5].
[191] Ibid [4]-[6].
[192] Ibid [8].
[193] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, p. 3.
[194] Ibid [4].
[195] Ibid [4].
[196] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [3].
[197] Ibid p74.
[198] Ibid p75.
[199] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, p72.
[200] Ibid [10], p75; Vol 7, Tab 29A, Second Statement of Matthew Barden, 28 August 2023, [12].
[201] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, p79.

to notify DCJ partners including the Client Referral Assessment Group ("CRAG") to manage referrals.[202]

124. CHPs are also encouraged to establish relationships with the Local Health District should a referral to the local health team be required.[203] Further, CHPs are responsible for identifying possible TA providers in their location and managing their relationship with such providers.[204] To receive funding and assistance, CHPs must be registered under the National Regulatory System for CHPs.[205] DCJ also provide training to CHPs via the Community Housing Industry Association NSW[206] and annual accountability meetings are held with CHPs.[207]

125. In the local area to which Jazzy moved after he left his mother's home, the relevant CHP was Hume Community Housing Association ("Hume Housing") .The court was informed that Lucy Andrews is the Manager of Housing Options at Hume Housing.[208] Hume Housing is contracted by DCJ to deliver housing assistance in the Southern Hunter New England Area, primarily in the Maitland and Port Stephens local government areas.[209] The management of properties in these areas was transferred from DCJ to Hume on 2 September 2019[210] on a 20-year lease so now Hume Housing is responsible for tenancy and services in that location.[211] As such, there is no DCJ Housing presence in that location.[212] Hume Housing use DCJ's Homes Operational Management Extended Services ("HOMES") system to enter details of the services delivered.[213]

126. Hume Housing are responsible for primarily managing relationships with Temporary Accommodation (TA) providers in their management area.[214] For example, Hume Housing manage the relationship with [redacted] where Jazzy was living at the time of his death. [redacted] is a TA provider.[215] Like many other TA providers, it is an independent business and, as such, Link2Home pay for the use of their facilities.[216] If a complaint is made about [redacted], this will be forwarded to Hume Housing for action as it is within their

[202] Ibid p80-81.
[203] Ibid p95.
[204] Ibid [15].
[205] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, p. 5.
[206] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [30].
[207] Ibid [28].
[208] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [10]; Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [4].
[209] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, [7], p101.
[210] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [5].
[211] Wilma Falcone, Transcript, 16 November 2023, p22.
[212] Ibid p21.
[213] Exhibit 12, Statement of Humair Ahmad, 15 November 2023, p52-53.
[214] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [5].
[215] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [5].
[216] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [18]; Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [19].

management area.[217] For example, if Housing Statewide Service receive a complaint about [redacted], the court was informed that they would divert the complaint to Hume Housing.[218] If Hume Housing approached Housing Statewide Services regarding a complaint about [redacted], Housing Statewide Services could provide general policy advice.[219]

127. Hume Housing is also responsible for ensuring that there are adequate TA providers in their area. For example, the court was informed that on 2 March 2022, a site inspection conducted at [redacted] revealed that it was not suitable for TA and needed to be removed from VMS immediately until further notice.[220] Within 10 minutes from receipt of this email by Link2Home, [redacted] was no longer 'ACTIVE' in the VMS.[221] As this resulted in Hume Housing not having any TA providers in the Port Stephen's area, a 'road show with Link2Home' was organised whereby DCJ representatives travel to a particular region to source and locate additional TA service providers. In this case, Hume Housing was contracted by DCJ to perform this 'road show' and DCJ representatives met with Hume Housing to provide guidance as to how to engage and cultivate working relationships with TA providers.[222] The court was informed that following a visit of the facilities and a meeting with the manager of [redacted] on 10 March 2022, Link2Home were notified that [redacted] could be used as a TA service provider for DV clients or for referrals from the NSW Police Force. As such, [redacted] was updated in the VMS as 'ACTIVE' within these parameters of usage.[223]

128. I note that it was somewhat perplexing and disturbing that the manager of [redacted] told this court, in direct conflict with the departmental evidence that he was unaware of the premises ever having been removed from the register. I will return to the state of the premises at [redacted] shortly.

129. [redacted] the manager of [redacted], confirmed that the premises had transitioned from providing motel services to the broader public to being a facility that primarily provided accommodation for Department of Housing clients.[224] Whilst accepting that it was not ideal, Ms Falcone gave evidence that the Department of Housing had been using motels since around 1997 due to demand outstripping supply and that this demand has only increased since 1997 so that approximately 2,100 households were in TA on any given day.[225] The number of persons exiting custody to TA for the year 2021/2022 was 1,603, many of whom

[217] Exhibit 9, Third Statement of Wilma Falcone, 19 October 2023, [8].
[218] Ibid [9].
[219] Ibid [10].
[220] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [10].
[221] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [11].
[222] Exhibit 10, Second Statement of Daryn Fallshaw, 10 November 2023, [10].
[223] Ibid [12].
[224] [redacted] Transcript, 16 November 2023, p6-7.
[225] Wilma Falcone, Transcript, 16 November 2023, p29-30.

would have complex support needs like Jazzy and this demand was nowhere near the limited capacity of the ERS program which can only 20 persons per year.[226]

The expert evidence

130. The inquest heard from Professor Eileen Baldry, Emeritus Professor of Criminology at the University of NSW who has had many years of experience reviewing how people with mental health disorders and cognitive disability (MHDCD) are managed by criminal legal agencies (police, courts, prisons and CC). She has conducted in depth research with Indigenous peoples and communities regarding MHDCD and criminal legal agencies and researched community sanctions in NSW.[227]

131. Professor Baldry was very critical of the assistance offered to Jazzy on release. Her criticisms were not of individual CC officers or community housing support workers, instead she drew the court's attention to the long term and systemic failure to provide the kind of comprehensive "wrap-around" support which could have addressed Jazzy's mental health, cognitive and AOD issues, using a trauma informed and culturally appropriate framework. She drew the court's attention to the fact that the problems are well known and have been the subject of past inquiries and commissions. She stated "If key recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADC), The NSW Law Reform Commission's Cognitive and Mental Impairments Inquiry and the ICE Inquiry had been fully implemented, [Jazzy] may not have ended up in these most tragic circumstances.[228] I accept her view.

132. Professor Baldry further noted the following:

(1) the support and supervision provided to Jazzy on parole was inadequate to address his complex support needs given his serious mental health issues, possible cognitive disability, drug use, childhood trauma and housing issues due to fragmenting of many different services and case workers;[229]

(2) Such services should be consistently case managed by the same case worker (not the CCO) across all services required and across geographical locations in a culturally appropriate manner such as the service provided by the CRC to avoid fragmentation of service delivery as was evidence in Jazzy's case across;[230]

[226] Vol 7, Tab 29Cb statistics; see also Wilma Falcone, Transcript, 16 November 2023, p32.
[227] Professor Eileen Baldry, Transcript, 16 November 2023, p34.
[228] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, p8.
[229] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, p7.
[230] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, p6; Professor Eileen Baldry, Transcript, 16 November 2023, p42, 49.

(3) CCOs need more services and resources in the community to which to refer people with complex support needs so that they can receive the integrated social and health services they require;[231]

(4) Red flags such as missing appointments, drug relapse and report of "sleeping a lot" would ideally have resulted in MCC (noting the lack of resources and funding that CCOs face) attending [redacted] earlier and seeing Jazzy in person. However the consistent specialised case worker model like CRC that allows for a civil society health focussed approach, rather than criminal justice supervision, which is focussed on managing community safety by addressing risk of offending and is bound by legislation governing CC, would have been better placed to meet these red flags;[232]

(5) Breaching Jazzy's parole in this context was not ideal and it would merely repeat the cycle of incarceration and release without addressing his real rehabilitation needs;[233]

(6) Motel type TA accommodation was not ideal for people with complex support needs and stable supported accommodation such as that provided by TSA and ERS and organisations such as the CRC are urgently needed to meet demand noting that 50% of people in prison have complex support needs;[234]

(7) The findings in relation to Jazzy were consistent with Recommendations 99 and 102 of the ICE Inquiry regarding the need for dedicated case management, safe and stable housing, primary and mental health services and drug treatment services on a health needs basis;[235]

(8) The appropriateness of LSR-I assessments for indigenous peoples and those with cognitive impairment was questionable as they are a one size fits all approach, noting that the assessments conducted on Jazzy over the course of his life did not result in the provision of a serious rehabilitation program;[236]

(9) Lack of services in regional areas would ideally be overcome by having the equivalent of a CRC in each regional town.[237]

133. I accept the evidence of Professor Baldry in its entirety and I note its importance when

[231] Vol 7, Tab 30, Expert report of Professor Eileen Baldry, p6.
[232] Professor Eileen Baldry, Transcript, 16 November 2023, p35, 39.
[233] Professor Eileen Baldry, Transcript, 16 November 2023, p44.
[234] Professor Eileen Baldry, Transcript, 16 November 2023, 31, p47.
[235] Professor Eileen Baldry, Transcript, 16 November 2023, p48.
[236] Professor Eileen Baldry, Transcript, 16 November 2023, p37.
[237] Professor Eileen Baldry, Transcript, 16 November 2023, p39, 50-51.

examining possible recommendations in this matter.

Evidence as to the state of [redacted]

134. Jazzy's family was very concerned about the state of the premises at [redacted], regarding them as highly inappropriate for Jazzy, given his known needs and vulnerabilities. In written submissions, Jazzy's family noted health and safety issues with his room and concerns around drug use by other [redacted] residents. In these circumstances, Jazzy's family were concerned that Jazzy was particularly vulnerable as he was on multiple Pharmaceutical Benefit Scheme medications which are often sought by drug dealers in exchange for ice. This was coupled with the fact that Jazzy had previously relapsed and offended whilst residing at [redacted] in the context of substance abuse. Further, Jazzy was living alone and lacked pro-social supports and access to psychologists or general practitioners in the Raymond Terrace area. Jazzy's family submitted that [redacted] was unsuitable for Jazzy as substance abuse was a high-risk factor for him reoffending.

135. Ms Anderson, who was a senior practitioner of Port Stephens Family and Neighbourhood Services gave evidence that [redacted] was affected by matters of hygiene and cleanliness, as well as high drug use, violence and intimidation and the presence of sex offenders.[238] Ms Anderson said she was in constant contact with Hume Housing about the state of [redacted] and Hume was in constant contact with [redacted].[239]

136. Mr McCarter gave evidence that Jazzy did not raise any concerns about the conditions at [redacted] and if he had done so Mr McCarter would have reflected his concerns in the case notes.[240] Mr McCarter was unaware of whether any complaints had been made by MCC to the Department of Housing regarding [redacted].[241] Nor was the manager of MCC, Ms Lane.[242] Mr McCarter gave evidence that he would steer clients away from [redacted] if there were other accommodation options available for "exactly the same" reasons as those stated by Ms Anderson.[243] The problem was the lack of alternative accommodation.

137. The manager of [redacted] gave evidence denying the characterisation of the state of [redacted] alleged by Ms Anderson. His evidence was that there had been occasions when issues as to the state of the premises had arisen, but they were dealt with promptly.[244] If behaviour indicative of drug use or violence was witnessed, [redacted] notified Hume Housing and where relevant, the Maitland Police Station. In those circumstances the person's

[238] Kylee Anderson, Transcript, 6 September 2023, p74.
[239] Kylee Anderson, Transcript, 6 September 2023, p75.
[240] Morgan McCarter, Transcript, 7 September 2023, p34.
[241] Morgan McCarter, Transcript, 7 September 2023, p36.
[242] Louise Lane, Transcript, 7 September 2023, p57.
[243] Morgan McCarter, Transcript, 7 September 2023, p31.
[244] [redacted] Transcript, 16 November 2023, p4-6.

accommodation would not be extended beyond 21 days.[245] [redacted] had employed a full-time security officer prior to 2021 when Jazzy was residing there and the police practice is to drive through the motel carpark twice daily.[246]

138. Complaints about [redacted] would be handled by Hume Housing, given Housing have outsourced service delivery, including responsibility for complaint handling. Ms Falcone gave evidence that it would be hard to envisage another means of management given the large number of TA providers.[247] A search of the Link2Home database disclosed some complaints regarding [redacted] For example, some complaints related to pets, positive cases of COVID-19 and lost room keys.[248] Another complaint identified as having been made in March 2021 related to a family being concerned about the premises as suitable for children given the attendance of police to do parole checks and the allegation that other residents were paedophiles and drug dealers.[249] There was evidence of one complaint in March 2022 after Jazzy's death that related to child protection and animal welfare concerns which resulted in [redacted] being removed temporarily from the list of TA providers. [redacted] was re-instated after an inspection 20 days later.[250] As I have stated, [redacted] gave evidence that he was unaware that [redacted] had been taken off the list as an appropriate TA provider for that period in March 2022.[251]

139. There was evidence before me which indicated recorded attendances by police at [redacted] for drug use on two occasions (March and April 2021) and one relating to domestic violence (April 2021).[252]

140. Counsel assisting submitted that "the evidence as to the alleged state of [redacted] is not directly relevant to the manner of Jazzy's death other than to the issue as to TA like [redacted] not constituting the appropriate type of accommodation with wrap-around services that is needed to address the complex needs of parolees like Jazzy upon their release from jail".

141. Counsel for Jazzy's family submitted that [redacted]'s status as a Temporary Accommodation Provider and Housing NSW's role in overseeing TA providers is relevant to this inquest as Jazzy had been previously referred to [redacted] as a TA provider by Hume Housing and PSFNS and Community Corrections were aware of [redacted] status as a TA provider. Jazzy's family submitted that PSFNS would not likely have referred Jazzy to [redacted] if it were not a TA provider.

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[245] Exhibit 8, Statement of [redacted] [5.3].
[246] Exhibit 8, Statement of [redacted] [6.3]-[6.4].
[247] Wilma Falcone, Transcript, 16 November 2023, p24-25.
[248] Exhibit 10, Statement of Daryn Fallshaw, [9].
[249] Exhibit 12, Statement of Humair Ahmad, Annexure, p125.
[250] Exhibit 10, Statement of Daryn Fallshaw, [9]-[13].
[251] [redacted] Transcript, 16 November 2023, p14.
[252] Exhibit 5, NSWPF COPS records summary.

142. I note that in fairness, [redacted] were given an opportunity to make final submissions on this issue, but nothing was forthcoming.

143. In weighing up this evidence I make the following findings. I accept the evidence of Ms Anderson from PSFNS about the dire state of [redacted] around the time of Jazzy's death. She gave her account in a straightforward manner with no evidence of exaggeration. Her account was effectively supported by Mr McCarter who told the court he would steer clients away from [redacted] for the same reasons, if there was something else available.[253] The picture they gave was of a place wholly unsuitable for providing adequate support for someone in Jazzy's situation.

144. Jazzy's family had submitted that PSFNS would have been unlikely to refer him there if [redacted] were not an official TA provider. I accept that the TA registration gave [redacted] some status, but the fact remains that PSFNS *did* assist Jazzy to stay there, well knowing the problems at that location. The referral was made simply because there was nothing else to offer in the local area and this is one of the tragedies of the whole situation.

The issues

145. This Inquest sought to focus on the manner of Jazzy's death by a consideration of the following matters set out in the Issues List.

1. Was the management of Mr Gibbs relocation to Raymond Terrace reasonable and appropriate (including with reference to relevant Housing and Community Corrections Policies and Procedures at the time) including:

(i) Assessment of risks relating to the move;

(ii) Assessment of prosocial supports relating to the move;

(iii) Assessment of appropriateness of residence (including what accommodation was available and how such accommodation is funded);

(iv) Assessment of the use of electronic monitoring during the period immediately after relocation;

(v) Arrangement of protective factors prior to move such as GP and psychologist;

(vi) Engagement with family as to the appropriateness of the move;

146. Counsel assisting was not critical of the CC officers involved in Jazzy's management post release. She submitted that the management of Jazzy's relocation to Raymond Terrace

[253] Morgan McCarter, Transcript, 7 September 2023, p31.

was reasonable and appropriate in the context of the lack of adequate resourcing of CCOs and the lack of wrap-around services like CRC for complex support needs parolees.

147. I accept that once Jazzy informed his CC officer that he was moving, that officer had little or nothing to offer him by way of supported accommodation. Further I understand the impulse to keep him engaged in some sort of supervision or at least contact by transferring him to the MCC once Jazzy had gone ahead and secured his own accommodation by contacting a service that had known previously.

148. Counsel assisting submitted that the risks that Jazzy presented, in terms of re-offending remained high whether he was in the Burwood or in the Raymond Terrace area. His LSR-I rating upon release from custody was the highest possible rating with the highest possible level of supervision and could not be further upgraded to address any increased risks resulting from relocation. Nor did CC policy allow for the refusal of transfer by a client. The focus of the CCOs was to facilitate supervision at any location rather than lose contact with a client.

149. The arrangement of protective factors such as contact with a GP and psychologist *prior* to the move was not something required by CC policy. Indeed, policy directed that finalisation of case plans prior to transfer, whilst ideal was not necessary and was not an appropriate reason to refuse transfer. Jazzy had a GP and psychologist arranged in the Burwood area including a MHCP which he told CCOs he was in the process of re-arranging in the Newcastle/Raymond Terrace area. Whilst MCC and PSFNS (accepting that the latter was unable to mandate attendance) could have assisted Jazzy with engagement with services once he had moved to Raymond Terrace, unfortunately Jazzy was not substantially engaged with either service prior to his death to facilitate this.

150. I accept that there is no criticism that can be properly directed to CC Officers in relation to the choice of [redacted] as Jazzy's accommodation. There was a complete lack of appropriate accommodation in the area. While [redacted] was an approved TA provider, Jazzy was not there pursuant to the TA program at the time of his death. In fact he had been referred to a possibility of TA in the Burwood area, which he did not pursue. Ms Anderson told the court that while she had assisted him, Jazzy was there as "a permanent weekly rental" and was self funding his accommodation. This is supported by [redacted] which produced a letter indicating that Jazzy was renting on a weekly basis.[254]

[254] See Vol 7, Tab 24, Statement of David Plowright, Annexure D.

151. The court was informed that Jazzy had stayed at [redacted] previously. The exact circumstances of Jazzy's previous stay at [redacted] in 2020 were not fully reviewed but it appears that he was initially at least housed as a TA client after Link2Home made a referral to the Port Stephens Family and Neighbourhood (PSFANS) specialist homelessness team.[255] The evidence suggests that he was accepted back to [redacted] in 2021 due to his having been previously known to the motel and having been referred as a housing client previously via Link2home. This second stay at [redacted] was as a result of a self-referral to PSFANS and was not pursuant to any suggestion or direction by a CC officer.

152. Motels are not suitable accommodation for housing supervised parolees with significant needs but are unfortunately used extensively across NSW due to a lack of social housing and supported accommodation. This results in untrained providers such as [redacted] operating as facilities for persons with complex supports needs like Jazzy. The lack of suitable *supported* TA providers in the Raymond Terrace area remains an issue of very significant concern.

153. The assessment of pro-social supports relating to the move was complicated, as Jazzy had deteriorated, relapsed and re-offended at both relevant locations in the past but also had some pro-social support in both places. I accept both options had pros and cons which had been considered by BCC prior to the move. This complicated situation informed Mr Plowright's decision not to communicate with Jazzy's mother [redacted] prior to the move as he was concerned about escalating Jazzy's distress which he thought had the potential to result in offending and/or harm to persons.

154. I accept counsel assisting's submission that the evidence in the inquest was clear that electronic monitoring was not appropriate in Jazzy's circumstances. I accept the focus of CC was on preventing re-offending and ensuring community safety, neither of which would have been assisted in Jazzy's case by the use of electronic monitoring. Electronic monitoring would not have detected a drug relapse or mental health deterioration.

155. Jazzy's family submitted that Jazzy's relocation to Raymond Terrace, in particular to [redacted], was not reasonable or appropriate. Jazzy's family raised concerns that Mr Plowright did not adequately assess the risks involved in Jazzy relocating to Raymond Terrace, including adequately considering his pro-social supports, the lack of general practitioners and psychologists available and the unsuitable nature of the accommodation. Further, they raised concerns that Mr Plowright did not speak to [redacted] or [redacted] about this relocation

[255] Vol 7, Tab 23, Statement of Kylee Anderson and file notes.

nor did he undertake a formal assessment as to the appropriateness of [redacted] Jazzy. In circumstances where Jazzy was vulnerable and at the highest risk of reoffending, Jazzy's family submitted that [redacted] home remained the more appropriate location for Jazzy.

156. Counsel for the Commissioner of CSNSW submitted that the management of Jazzy's relocation to Raymond Terrace was reasonable and in accordance with Community Corrections policies. It was submitted that Mr Plowright appropriately considered the risk of Jazzy's relocation, including considering the pro-social supports at Burwood and Raymond Terrace, and developed a clear plan for Jazzy's relocation with the support of Ms Anderson of PSFNS. Further, Mr Plowright sought to facilitate Jazzy's engagement with Community Corrections rather than refusing a transfer which may have led to disengagement and an increased risk of reoffending. Although [redacted] was recognised to be an "imperfect situation", it was submitted that this was the only option for people who are homeless or transient in that area until other opportunities arose.

157. I have no trouble accepting the family's submission that the [redacted] accommodation was wholly unsuitable for Jazzy. However, I do not see that Mr Plowright had many available options when Jazzy appeared determined to leave his mother's house. I understand the impulse to encourage Jazzy to remain in contact with a CC officer, even if that officer was in another area. I agree with the submission of CSNSW that had a transfer been refused, it is most likely Jazzy would have cut all contact and moved to [redacted] anyway. Jazzy found that accommodation himself, it does not appear to have been suggested or supported by any CC Officer. The problem is not so much whether or not [redacted] was suitable – it clearly was not, what Mr Plowright had to grapple with was how to keep Jazzy engaged and how to encourage him to at least remain open to supervision. I note that CC policy did not support Mr Plowright refusing the move.

158. At the conclusion of the evidence I was not critical of the individual officer, in my view he was faced with a very difficult situation when Jazzy decided to move and his actions were in all the circumstances reasonable given the constraints he was working under.

2. Was the management of Mr Gibbs once he had relocated to Raymond Terrace reasonable and appropriate (including with reference to relevant Housing and Community Corrections Policies and Procedures at the time) including:

(i) Provision of assistance in arranging GP and psychologist;

(ii) Administration of drug testing;

(iii) Direction regarding abstinence once relapse was reported and whether any

assistance provided in developing strategies or connecting to drug and alcohol counselling;

(iv) Maintenance of supervision once relapse reported and contact lapsed;

(v) Engagement with family as to concerns about Mr Gibbs relapse;

(vi) Extent of supervision provided by accommodation;

159. Counsel assisting submitted that the management of Jazzy once he had relocated to Raymond Terrace was reasonable and appropriate in the context of the lack of adequate resourcing of CCOs and the lack of available wrap-around services like CRC for complex support needs parolees.

160. Professor Baldry noted that MCC could have done more to substantiate that Jazzy had arranged a GP and psychologist, however she accepted the difficulties arising from under resourcing and the inability of a service like CC to meet the needs of complex clients like Jazzy. Whilst MCC and PSFNS could have assisted Jazzy in trying to find appropriate services, unfortunately Jazzy was not substantially engaged with either service prior to his death. PSFNS also had the limitation of not being a mandated service and so it could only assist Jazzy if he requested such assistance and then chose to attend.

161. Whilst Jazzy might have been drug tested by MCC when he disclosed a relapse, the CC policy did not dictate that drug testing occur, particularly in the context of a freely given admission when the result was unlikely to change the decision of the CCO as to how to proceed. The evidence was clear that parolees would not be breached for one disclosure of relapse or indeed a single positive drug test. The focus of CC was on supporting the parolee in the community to remain drug free so that they could remain crime free, and there was an acceptance that this may take some time. The process involves building rapport, finding appropriate drug treatment services and only moving to a parole breach as the last resort. The court was informed that this is an approach that is endorsed by the State Parole Authority. It appears appropriate and generally in line with relevant harm reduction principles. The breach of Jazzy's parole on the basis of a single disclosure of drug use would likely have resulted in the SPA rejecting the breach report and directing CC to continue to manage him in the community.

162. In any event, the return of a parolee to custody to serve the remainder of their sentence would only result in a later release to the community without any parole supervision whatsoever. The decision of what to do about a relapse should be determined by the designated CCO as a matter of practice and as Jazzy had attended on a date that he was

not booked to attend, he had been seen by a non-designated CCO Ms Davies, who would not, as a matter of practice, decide how to deal with the relapse. Jazzy's designated CCO Mr McCarter, upon seeing the report of drug use and becoming aware of Jazzy's non-attendance at his next appointment attended [redacted] to follow up what was happening for Jazzy. This was appropriate. Unfortunately, Jazzy was not present and no further contact was able to be made prior to Jazzy's death.

163. Professor Baldry noted that red flags such as missed appointments, drug relapse and the report of "sleeping a lot" would ideally have resulted in MCC (accepting the lack of resources) attending [redacted] earlier and seeing Jazzy in person. However, what was really called for was the participation of a specialised case worker from a service like CRC. Professor Baldry noted that what was actually required was a civil society health focussed approach, rather than criminal justice supervision which is focussed on managing community safety by addressing the risk of re-offending.

164. The level of supervision provided by [redacted] was minimal or non-existent, The Manager received no training as a TA provider. If behaviour indicative of drug use or violence was witnessed the [redacted] manager stated they notified Hume Housing and where relevant Maitland Police Station and the person's accommodation would not be extended beyond 21 days. Additionally, a full-time security officer was on-site and the police drove through the motel carpark twice daily. I accept it is unrealistic to expect any motel managers to act as a social worker or to put their customers ahead of their need to turn a profit. This is the problem inherent in a system which outsources care and does not provide adequate social and supported housing.

165. Counsel for Jazzy's family submitted that Jazzy was not appropriately supervised by Maitland Community Corrections. Upon Jazzy's relocation to Raymond Terrace, Jazzy's family are of the view that MCC should have immediately obtained support from a general practitioner and a psychologist for Jazzy considering his known mental health issues. Jazzy's family also raised concerns with Jazzy not being seen by his designated Community Corrections Officer, Mr McCarter, but rather by two other officers. Regarding Jazzy breaching his parole conditions, Jazzy's family were concerned that Maitland Community Corrections did not drug test him, direct him to seek medical or mental health treatment, did not increase his supervision nor did they inform the family of these issues. Jazzy's family submitted that Maitland Community Corrections should have intervened at this time due to Jazzy's vulnerability and high-risk status, or at the very least they could have altered his supervision as opposed to 'giving him time.'

166. Counsel for CS submitted that the management of Jazzy's return to Raymond Terrace was both reasonable and in accordance with policy. Between 7 April 2021 and 7 May 2021 officers from MCC made numerous attempts to contact Jazzy. Jazzy's attendance at MCC was irregular, but the court heard that his designated officer Mr McCarter left messages for Jazzy on 15 April 2021 and again on 20 April 2021. On 23 April 2021 when Jazzy had still not been in contact Mr McCarter attended [redacted] to find him. When they finally spoke on 28 April 2021, Jazzy was directed to attend on 3 May 2021. Tragically on that day Mr McCarter was informed by [redacted] that Jazzy was in John Hunter Hospital after an "ice binge".

167. Mr McCarter gave evidence before me and impressed this court as a dedicated professional. I am not critical of his actions. However, the lack of resourcing, poor accommodation in which Jazzy was living and the shortage of support available in the community clearly impacted on the supervision provided.

3. Was the management of Mr Gibbs by Community Corrections reasonable

168. Counsel assisting submitted that the management of Jazzy was reasonable and appropriate in the context of the lack of adequate resourcing of CCOs and the lack of wrap-around services like CRC for complex support needs parolees.

169. Counsel for the Commissioner of CSNSW submitted that the overall management of Jazzy by Community Corrections was reasonable and in accordance with Community Corrections policies and procedures and the Service Delivery Standards according to Jazzy's 'tier 3/high risk rating.' Counsel recognised limitations to resourcing, external service providers and COVID-19 restrictions which impacted on Jazzy's supervision and welcomed further funding for external and wrap-around service providers that play an important role in the supervision and support of offenders in the community.

170. Counsel for Jazzy's family submitted that the management of Jazzy by Community Corrections was not appropriate considering his risk factors and vulnerable status. Jazzy's family raised concerns regarding Jazzy being able to transfer to [redacted] TA accommodation which was not assessed with reference to Jazzy, the lack of provision of mental health and addiction support for Jazzy once he relocated and the lack of consequences imposed on Jazzy or change in supervision style when Jazzy breached his parole conditions. Jazzy's family submitted that Jazzy should have remained with [redacted] and his stepfather where he was being meaningfully supervised by Community Corrections.

171. While I am very sympathetic to the concerns of Jazzy's family, I see the issue as one not so much of poor CC supervision, as poor overall support. I am convinced that what Jazzy needed was a dedicated support worker from outside Community Corrections, rather than a CCO who demanded better compliance or undertook hasty breach action.

The need for recommendations pursuant to s 82 Coroners Act

172. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

173. Counsel assisting put forward a number of draft recommendations for consideration which I will now consider in turn.

To the Commissioner of Corrective Services NSW

(1) To Advocate for an increase in both funding and the roll out of wrap-around services for parolees with complex needs including case managers such as those provided by the Community Restorative Centre consistent with recommendations of the Special Inquiry into the drug 'Ice".

174. Counsel for CSNSW submitted that CSNSW support the intent of the proposed recommendation to facilitate effective post release support for parolees with complex needs. CSNSW agreed that the availability of wrap-around services, such as the Community Restorative Centre, play an important role in the management of parolees, particularly those who face complex and multi-dimensional needs. CSNSW acknowledge that the demand for such services outweighs the supply due to limited funding.

175. CSNSW drew the court's attention to a new program, announced in November 2023 - the Post Custodial Support (PCS) program which has now been funded as part of the NSW Government's response to The Ice Inquiry. The PCS will provide intensive and comprehensive treatment and support for people leaving custody who have a risk of harmful drug and alcohol use. As I have stated earlier such programs need urgent implementation.

176. I accept CSNSW's submission that the recommendation can properly be limited to recommendations 99 and 102 of the Ice Inquiry, in keeping with the evidence and issues raised at this inquest. I intend to make the recommendation in those terms.

(2) To ensure adequate training of Community Corrections Officers in mental health and complex support needs clients.

177. This recommendation emerged from the evidence of CCO Mr Plowright who stated that he felt more mental health training would be beneficial to officers in his position.[256] It was

[256] 6/9/23 Plowright page 58

supported by Jazzy's family who identified the gaps in the assistance Jazzy received for his mental health issues.

178. Counsel for CSNSW submitted that CSNSW supported the intent of this recommendation and the importance of training CCOs in mental health and complex support needs clients. An alternative formulation was suggested given that while the issue was raised in evidence, the court did not have comprehensive information about current training. I accept that submission and intend to make the recommendation in the form suggested.

(3) To Review Community Corrections Policies and Practices to ensure continuity of service to complex support needs parolees by their designated Community Corrections Officer

179. I note that CSWNSW accept this recommendation and express a willingness to review the relevant policies.

180. Jazzy's family also supported this recommendation, however, I note they also seek a review of policies relating to the transfer of parolees, particularly those with complex needs, the completion of Risk Mitigation Plans for transfers and breaches of parole conditions and the supervision of community corrections officers. These are important issues but in my view, given the limited evidence in this inquest such extensive reviews may be beyond scope.

(4) To negotiate uniform Memorandums of Understanding and/or Service Agreements as between government organisations including Department of Community Corrections, Department of Communities and Justice and non-government organisations including Port Stephens Family and Neighbourhood Service and Temporary Accommodation providers including [redacted]

181. CSWNW agreed with the intent of this recommendation calling, as it does for stronger collaboration and cooperation between various organisations and entities. However CSNSW submitted that the suggested proposal "would not be practical in light of the evolving needs of parolees, changing availabilities of non-government services and consent requirements to share personal information".

182. An alternative was suggested which would serve to assist in clarifying roles and strengthening understanding between relevant agencies.

183. Having considered the issues I intend to make the recommendation suggested by CSNSW.

To the Secretary, Department of Communities and Justice

184. I note that counsel for Housing Statewide Services, DCJ suggested that these

recommendations were best directed to particular officers within the Department, that is to the Director of Housing Statewide Services and the Executive Director of Housing, Homelessness, Disability and Seniors. While this may be correct, I am of the view that the recommendations may be best considered by the Departmental head and then re-directed.

(5) To consider a long term strategy to move away from heavy reliance on motel accommodation for parolees at risk of homelessness.

185. At the conclusion of these proceedings I remained extremely concerned about the heavy reliance on motel accommodation for people like Jazzy on their release from custody. While he had a supportive mother, for whatever reason he was not prepared to stay with her. In my view he was effectively homeless and in need of an emergency bed. He fell back on an option he had previously been referred to through Link2home, the motel accommodation provided by [redacted]

186. He may have been self-referred on this occasion but it is worth noting that his parole officer apparently had no *supported* accommodation option to suggest.

187. I accept the submissions of counsel for Housing Statewide Services, (DCJ) that in the first instance DCJ will, as a matter of course, seek to refer a client experiencing or at risk of experiencing homelessness to a SHS if support is indicated. It was submitted that only if nothing is available will simple TA assistance be offered. While there are some supported TA (STA) providers which offer support as well as accommodation, most TA is provided by commercial operators, like motels or hotels, paid on a fee for service basis. I understand the submission that the emergency nature of some requests will sometimes necessitate the use of motels and hotels and for that reason I accept that it may well be an integral part of the overall system, particularly in rural NSW. Nevertheless I remain extremely concerned about our over-reliance on these commercial providers.

188. While counsel for DCJ stated that motels are only used as “temporary or crisis accommodation” or as “a stepping stone”. I do not think this is the case. The statistics before me suggest otherwise.

189. In my view there is a clear need to expand the available options for those leaving custody. Some good programs are already in place, but they need to be rolled out more widely if they are to create effective change and for that reason I have decided to expand the recommendation to include counsel for DCJ’s suggestion about the need to specifically advocate for increased funding of SHS.

190. Further I take up the suggestion that there should be a refinement of inspection procedures for TA and I intend to make the recommendation in the terms suggested.

(6) To negotiate uniform Memorandums of Understanding and/or Service Agreements

as between government organisations including Department of Community Corrections, Department of Communities and Justice and non-government organisations including Port Stephens Family and Neighbourhood Service and Temporary Accommodation providers including [redacted]

191. I note that counsel for Housing Statewide Services, DCJ submitted that DCJ Housing agreed with "the intent of the recommendation to promote collaboration between DCJ, CSNSW and non-government organisations such as PSFANS and TA providers." However, given Community Corrections which is a division of CSNSW and DCJ Housing both fall under the Department of Communities and Justice a MOU is not the appropriate vehicle to improve collaboration.

192. I note that there was evidence before me about a local inter-agency meeting in the Raymond Terrace area which had to some degree improved relationships and it may be that local arrangements such as this are the most crucial to pursue.

193. Counsel for Housing Statewide Services proposed two alternate recommendations aimed as a "viable alternative to negotiating Memorandums of Understanding and Service Agreements." I accept that the proposed recommendations aim to encourage the continuation of collaboration between DCJ Housing and CSNSW and the provision of information to confirm the service expectations and processes in place to ensure the ongoing suitability of TA providers. I intend to make the recommendations suggested.

Findings

194. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

195. The person who died was Jasmynd Gibbs

Date of death

196. He died on 7 May 2021

Place of death

197. He died at John Hunter Hospital, Newcastle

Cause of death

198. He died of complications of methylamphetamine use

Manner of death

199. His death occurred in circumstances of a drug relapse whilst on supervised parole. Jazzy had complex needs and required comprehensive "wrap-around" support which was not available.

Recommendations pursuant to section 82 *Coroners Act 2009*

200. For reasons stated above I make the following recommendations

To the Commissioner of Corrective Services

(1) To Advocate for an increase in both funding and the roll out of wrap-around services for parolees with complex needs including case managers such as those provided by the Community Restorative Centre consistent with the recommendations 99 +and 102 of the special Inquiry into the drug 'Ice".

(2) Review training on mental health and complex support needs to identify whether it meets the needs of Community Corrections Officers.

(3) To Review Community Corrections Policies and Practices to ensure continuity of service to complex support needs parolees by their designated Community Corrections Officer.

(4) To consider the publication of an information sheet on the role of Corrective Services NSW, the aims of community based supervision and the ways in which non-government organisations can support the management of offenders in the community.

To the Secretary of the Department of Communities and Justice – for the attention of Director of Housing Statewide Services and the Executive Director of Housing, Homelessness, Disability and Seniors

(5) To consider a long term strategy to move away from heavy reliance on motel accommodation for parolees at risk of homelessness, which must involve strategies such as increased funding for Specialist Homelessness Services that can provide wrap-around services.

(6) To Continue the refinement of procedures, as appropriate, requiring annual inspections of Temporary Accommodation providers to ensure ongoing suitability.

(7) To continue collaboration with Corrective Services NSW to provide housing assistance for inmates and parolees who are at risk of homelessness, including the development of a Housing Portal on inmate tablets which provides information about housing services, products and assistance prior to release from custody.

(8) To consider the development of an information pack to be provided to Temporary Accommodation providers, outlining annual inspections that are to be completed by DCJ

Housing offices or Social Housing Management Transfer location community housing providers (SHMT CHPs) as well as the contact details for any complaints raised by the TA provider or TA guest.

Conclusion

201. The problems Jazzy faced require a different approach to that which emerged in the evidence. Jazzy required intensive wrap-around support for his complex needs and that care was best delivered separately to the CC supervision regime he was under. While this kind of wrap-around support doesn't exist or is rare, I can understand Jazzy's family seeing the issue as a failure of CC supervision. Unfortunately the kind of support CC officers are able to provide was never going to work for Jazzy, no matter how well meaning or competent individual officers may have been.

202. I offer my sincere thanks to counsel assisting Rebekah Rodger, and her instructing solicitors Sarah Crellin and Amy Halliwell for their very great assistance in this matter. I also note the cooperative manner in which parties approached these proceedings.

203. Finally, once again I offer my sincere condolences to Jazzy's family. His life was cut short in circumstances where our community had failed him over many years. His final release from custody was no different. Once he left his mother's home, he had no appropriate accommodation and lacked support. He returned to a motel where he had a history of drug use and within weeks he was dead. I echo Professor Baldry's sentiments in saying much of what needs to be done is already clear and has been the subject of extensive public inquiry. Steps such as fully implementing the recommendations of the Ice Inquiry would certainly be a step in the right direction.

204. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court, Lidcombe
20 February 2024