CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Timothy Garner
Hearing dates:	28 February 2023; 2, 7, 9 and 14 March 2023; 1 August 2023
Date of Findings:	1 February 2024
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, risk assessment, psychiatric assessment, mental health review, self-inflicted death, cell architecture, Metropolitan Remand & Reception Centre, Risk Intervention Team management, Mental Health Screening Unit waitlist, communication with families
File number:	2018/00209734
Representation:	Dr C Palmer, Counsel Assisting, instructed by Mr L Sampson & Mr J Pender (Crown Solicitor's Office) Mr P Aitken for the Commissioner of Corrective Services New South Wales, instructed by Department of Communities & Justice Ms H Donaldson (Aboriginal Legal Service) for Ms M Garner Mr J Etkind for Ms D Moffitt, instructed by Karim + Nicol Lawyers Ms B Haider (New South Wales Nurses & Midwives Association) for Registered Nurse B Kiy Mr J Harris for Justice Health & Forensic Mental Health Network & Registered Nurse W Zifamba , instructed by Hicksons Lawyers Mr S Russell for Mr F Cunningham & Mr S Izgun, instructed by McNally Jones Staff Lawyers

Findings:

Timothy Garner died on 7 July 2018, whilst in lawful custody, at the Metropolitan Remand & Reception Centre, Silverwater NSW 2128.

The cause of Timothy's death was hanging. Timothy died as a result of actions taken by him with the intention of ending his life.

Recommendations made pursuant to section 82, *Coroners Act 2009*

1. I recommend that the Commissioner of Corrective Services New South Wales consider the introduction of, at a minimum, 5-yearly refresher training for all staff who are members of Risk Intervention Teams.

2. I recommend that the Commissioner of Corrective Services New South Wales continue to monitor the progress of refurbishments at the Metropolitan Remand & Reception Centre with the aim of ensuring that all inmates subject to Risk Intervention Team management are housed in O-Block or a refurbished cell in Darcy Pod by the end of 2024.

Table of Contents

1. Introduction

1.1 Timothy Garner, a First Nations man, was in lawful custody at a correctional centre at the time of his death on 7 July 2018. He had entered custody some three months earlier after being arrested on 8 April 2018. During his time in custody, Tim (as he was known to his family and friends) was assessed as having a psychotic illness, engaged in episodes of self-harm and showed disordered and distressed behaviour. This resulted in Tim being placed under certain protocols designed to manage his risk of self-harm.

1.2 On the evening of 7 July 2018, during a routine medication round, Tim was found in his cell, suspended from a ligature and showing no signs of life. Despite resuscitation attempts, Tim could not be revived and was, tragically, pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**).

2.4 In Tim's case, questions arose about the nature and adequacy of his management by CSNSW and Justice Health whilst in custody.

2.5 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Tim's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Tim was born in 1987 to Michelle Garner and Wayne Robinson. He grew up in the family home in Gorokan on the Central Coast. That country is the land of the Darkinjung people. Tim's parents separated soon after he was born and his father had limited involvement in his life. Michelle later formed a relationship with Craig Thorley who moved in the family home and was a stepfather to Tim.

3.3 Tim was a happy, warm and kind-hearted child. He attended Gorokan Primary School and then Gorokan High School until Year 10 before leaving to seek employment but found this to be a challenging process. In 2014, Tim formed a relationship with SD, who he had known since she was 11 years old. They had two children together, PG and TG. Tim embraced his new role as father wholeheartedly and was devoted to his children. Following TG's birth, she was diagnosed with profound deafness in both ears and cerebral palsy. This was very difficult for both Tim and SD, and affected them greatly.

3.4 Michelle describes Tim as a loving father to his two beautiful girls. He was a much-much loved son, nephew and good friend to many. There is no doubt that he is greatly missed. The thought of Tim's daughters being without their father is heartbreaking. They have already told Michelle that their memories of Tim are beginning to fade. But the adults who knew and loved Tim the most will ensure that his memory does not fade, and that he is remembered with much love and fondness.

4. Tim's medical history

4.1 When he was about 19 or 20 years old, Tim was diagnosed with bipolar disorder. Although he was prescribed medication, Tim was not always compliant with it.

4.2 From about November 2017, Michelle observed a change in Tim's behaviour. He showed increasingly paranoid behaviour, referred to hearing voices, and would pace up and down at the family home, talking to himself. After seeing a general practitioner, Tim was prescribed further medication. Although he took this medication more regularly Michelle did not observe any noticeable improvement in Tim's condition.

4.3 In early April, Tim stayed with his mother. He complained of hearing voices and told Michelle that the voices were telling him to do bad things. Michelle observed that Tim appeared scared and she became concerned for him. On 4 April 2018, Tim was diagnosed with schizophrenia by his general practitioner. He was prescribed quetiapine and diazepam and schedule for a follow-up appointment on 10 April 2018.

4.4 On 7 April 2018, Tim attended his uncle's wedding near Gorokan. Michelle noticed that Tim was pacing up and down, and had to leave the venue with SD, returning to Michelle's home. Later that

night at around 11:00pm, Tim was noticed to be agitated, displaying paranoid behaviour and holding his head.

4.5 SD took Tim to Wyong Hospital that evening for assessment. After being triaged the following morning, Tim subsequently left the hospital without seeking further treatment as he believed that something was going to happen to Michelle.

5. Tim's custodial history

5.1 Tim had interactions with the criminal justice system from a young age and had previously spent time in custody after being convicted of offences, mainly property-related in nature. From this period, Tim also engaged in illicit drug use which was often related to his offending.

5.2 On 8 April 2018, Tim was arrested in relation to a number of offences. After being taken into custody at Wyong Police Station, Tim entered CSNSW custody at Parklea Correctional Centre on 11 April 2018.

5.3 During a Reception Screening Assessment (**RSA**), Tim denied any medical or mental health concerns, and any thoughts of self-harm. Tim did not disclose his recent presentation to Wyong Hospital on 7 April 2018, or that he had a history of hearing voices.

5.4 Tim subsequently voiced concerns for his safety, stating that he had been named as the head of a gang at Parklea and that other inmates suspected that he was an alleged rapist. As a result, on 19 May 2018, Tim was transferred from Parklea to the Metropolitan Remand & Reception Centre (**MRRC**).

5.5 On 22 May 2018, Tim ran towards an office window and head-butted it, before head-butting an office door. He was subsequently placed in a safe cell for 24 hours observation.

5.6 On 23 May 2018, Tim was reviewed by a Risk Intervention Team (**RIT**). He denied any thoughts of self-harm, and described the incident the previous day as a way to "get out of the Pod". Tim disclosed a history of mental health issues and his presentation to Wyong Hospital on 7 April 2018. He also reported occasional auditory hallucinations. The RIT assessed Tim as suffering from "*excessively paranoid ideation*", and found that he appeared "*manipulative*" but was not at immediate risk of self-harm. Tim was placed on a waitlist to see a mental health nurse, and normal cell placement was recommended.

5.7 On 24 May 2018, Tim was found to have small superficial cuts to both forearms. The Primary Health Clinic Nurse (**PHCN**) was notified. Tim reported feeling suicidal, hearing voices and having thoughts to "slash up". He was kept on RIT conditions.

5.8 On 25 May 2018, another RIT review was conducted and Tim was assessed as being at risk of self-harm at the time. His placement on RIT conditions was continued.

5.9 On 28 May 2018, a further RIT review was conducted. Tim again reported hearing voices but denied that they told him to hurt himself. It was noted that he was not receiving any medication for

schizophrenia or bipolar disorder. Tim was deemed suitable for normal cell placement during the day, but was assigned to a safe cell at night.

5.10 On 30 May 2018, Tim was reviewed again by a RIT. He reported that he was no longer hearing voices and that his appetite and sleeping patterns were normal. However, Tim indicated that he was "*spinning out in the Pod*" and expressed a desire to be housed in a single cell. A Health Problem Notification Form (**HPNF**) was completed indicating that Tim had been cleared from RIT management and was to be housed in a group placement before review by a PHCN.

5.11 On 31 May 2018, Tim banged his head in his cell and suffered superficial cuts. He was reviewed by a PHCN but refused to answer questions. Tim's mood was noted as unstable and he was placed back on a RIT protocol.

5.12 On 1 June 2018, Tim was reviewed by a RIT. As he could not guarantee his safety, Tim was kept in a safe cell with a recommendation from the RIT that he be seen by a psychiatrist.

5.13 On 2 June 2018, Tim was seen by a Registered Nurse (**RN**) for a mental health review to consider changes to his placement and management. However, a comprehensive assessment could not be conducted as Tim was not forthcoming with information and he remained in a safe cell. Tim reported his previous presentations to Wyong Hospital and showed symptoms of paranoia. It was noted that Tim had multiple lacerations on his arms and a visible bruise to his mid temporal area.

5.14 On 3 June 2018, Tim was reviewed by a RIT. He denied thoughts of self-harm but it was noted that he presented with a flat affect, was uncooperative and remained at risk of harm from himself and from his peers.

5.15 On 6 June 2018, a further RIT review was conducted which Tim attended reluctantly. It was noted that he sat with his head on the table, was softly spoken, and answered every question with, "*I don't' know*".

5.16 On 8 June 2018, a RIT review was scheduled but Tim refused to come out of his cell and engage with the RIT.

5.17 On 10 June 2018, Tim was again reviewed by a RIT. He reported that he "spun out" in the Pod, but denied any thoughts of self-harm and hearing voices. Tim indicated that he did not wish to remain under RIT management. The RIT cleared Tim for group placement. Later that evening, Tim's cellmate reported that Tim had "slashed up". Tim denied any hallucinations but was found to have a superficial laceration on his forearm. He was taken to the clinic and later placed in a safe cell.

5.18 On 14 June 2018, Tim allegedly attempted to choke his cellmate after accusing him of being a "*snitch*" and "*undercover correctional officer*". Tim was placed in an assessment cell.

5.19 On 15 June 2018, Tim was reviewed by a RIT and noted to be paranoid and worried that he may have HIV after sharing needles with others in custody. Tim was commenced on quetiapine and urgently referred to psychiatry. A MNF was completed recommending that Tim be housed in a one-out cell pending psychiatrist review.

5.20 On 18 June 2018, a further RIT review was conducted. Tim presented as forthcoming, denying thoughts of self-harm and indicating that he wanted to remain out of his cell. His one-out cell placement was continued.

5.21 On 22 June 2018, Tim was reviewed by Dr Hearps, a psychiatrist. He reported generalised persecutory beliefs, that he was still hearing voices, and sleeping poorly. Tim denied any current suicidal ideation and indicated that his existing medication regime was helping. Dr Hearps noted that Tim was dishevelled, dismissive and irritable. Due to his risk to others, Tim's one-out cell placement was continued, his quetiapine dose was increased, and he was placed on a waitlist for a bed in the Mental Health Screening Unit (**MHSU**), with review in two weeks' time.

5.22 On 22 June 2018, Tim allegedly ripped the sink off his cell wall and smashed it. He was seen by Justice Health staff and treated for multiple deep lacerations to his finger, left knee and both feet.

5.23 On 23 June 2018, Tim refused to take his medication and was noted to be experiencing increasing paranoia, he was verbally aggressive and increasingly agitated. A considerable amount of faecal matter was observed to have been smeared on his cell door.

5.24 On 24 June 2018, Tim continued to refuse his medication and his mental state continued to deteriorate. After suffering an injury to his forehead from banging his head on the floor, Tim was taken to Westmead Hospital for treatment and discharged the next day.

5.25 On 25 June 2018, Tim was reviewed by Dr Sunny Wade, psychiatrist. He reported that his paranoia had improved slightly, that his auditory hallucinations were ongoing and stated that his mind was being read but denied hearing any commands. Dr Wade found that Tim presented as suffering from a psychotic illness with thought disorder and delusions, hallucinations and disorganised behaviour. It was also noted that Tim presented as a risk of harm to himself and to others, and that he had been non-compliant with his medications.

5.26 On 26 June 2018, Tim was reviewed by Dr Anna Farrar. He denied having experienced any mental health issues whilst in the community, and admitted to use of buprenorphine and heroin, having last used in custody at Parklea. On the same day, Tim was reviewed by a RIT and denied thoughts of self-harm and indicated that he was compliant with his medication.

5.27 On 28 June 2018, Dr Wade and Dr Farrar deemed Tim to be a mentally ill person for the purposes of section 55 of the *Mental Health (Forensic Provisions) Act 1990*, and an order was made for him to be transferred to the Mental Health Unit at Long Bay Hospital. Tim was noted to have delusions, probable hallucinations, probable thought disorder, and that he hit his head on the floor due to distress and refused, without reason, to drink water. A RIT review was scheduled for the same day but no assessment was performed as Tim refused to attend.

5.28 On 30 June 2018, Tim attended a review and reported auditory hallucinations but denied current thoughts of self-harm. He presented with a blunted affect and underlying irritability. The impression was that Tim remained psychotic and at risk, but was improving. Tim was kept in a one-out assessment cell and it was noted that he was to remain in Darcy Pod until transferred to the MHSU or Long Bay Hospital.

5.29 On 2 July 2018, a RIT reviewed Tim. He denied thoughts of self-harm and actions which would harm others. Tim expressed a desire to leave the MRRC, particularly Darcy Pod. A HPNF was completed, clearing Tim from RIT protocols, and to be housed in a one-out cell and held in Darcy Pod until a bed became available in the MHSU or Long Bay Hospital.

5.30 Later on 2 July 2018, Dr Wade performed a follow-up review with Tim. It was noted that he had improved since his review by Dr Farrar on 26 June 2018, that his observations were stable, and that he was less distressed, irritable and disorganised than his last review. Dr Wade also noted that Tim was adherent to olanzapine and that his dietary and fluid intake had improved. Dr Wade noted that there were no current concerns in relation to thoughts of self-harm, and no recent harm to others and self which would require ongoing monitoring. Dr Wade considered that Tim remained unwell but was not able to be managed in the MHSU, noting also that Tim had been discussed at the Long Bay Hospital bed demand meeting. The plan was for one-out cell placement, with a low threshold for return to RIT management if Tim experienced any thoughts of self-harm, and for review by a mental health nurse in three days, and review by a psychiatrist in a week.

5.31 At around 3:09pm on 7 July 2018, Tim was observed in his cell following a lockdown of the MRRC due to an unrelated incident. At around 7:55pm, Tim's cell door was opened by CSNSW and Justice Health staff so that he could receive his evening medication. He was found hanging from the fire sprinkler in his cell with a sheet around his neck. Tim showed no signs of life. Resuscitation efforts were commenced by staff on site and continued by paramedic services who were called to attend. Despite these efforts, Tim could not be revived and was later pronounced life extinct.

6. The post-mortem examination

6.1 Tim was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 10 July 2018. This examination identified the following relevant findings:

(a) fractures of the superior comua of the thyroid cartilage bilaterally;

(b) a visible ligature mark, the dimensions of which generally matched the sheet ligature, which encircled the neck and sloped upward into the occiput; and

(c) toxicological analysis was negative for alcohol, common illicit drugs and prescription medication.

6.2 In the autopsy report dated 9 April 2019, Dr Burger opined that the cause of Tim's death was in keeping with hanging.

7. What issues did the inquest examine?

7.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) The adequacy and the appropriateness of the processes and policies pursuant to which Tim was "cleared" by the RIT in 2018, including on 30 May 2018, 10 June 2018, 18 June 2018 and 2 July 2018;

(2) The nature, regularity, and suitability of the psychiatric assessments of Tim carried out whilst he was in Darcy Pod;

(3) The adequacy and appropriateness of the management plans developed with respect to Tim whilst he was in Darcy Pod;

(4) The adequacy and appropriateness of the monitoring and review of Tim carried out between 2 July 2018 and 7 July 2018;

(5) The adequacy and the appropriateness of the processes and policies pursuant to which Tim was "taken off the Long Bay Hospital schedule but was noted to remain on the MHSU wait list" at the bed demand meeting on or around 2 July 2018;

(6) The management of Tim's prescription medication requirements from the date he was received into custody until the date of his death, including:

   (a) the processes and policies pursuant to which Mr Garner's prescription medication requirements were ascertained upon his entry into custody;

   (b) the reasons for the delay Tim experienced between 28 May 2018 and 6 June 2018 in obtaining prescription medication; and

   (c) whether the change in medication from Seroquel to Olanzapine in late June 2018 was appropriate in the circumstances; and

(7) Whether, with the benefit of hindsight and reflection, any steps could have been taken by CSNSW or Justice Health that may have led to a different and better outcome for Tim.

7.2 In order to assist with consideration of some of the above issues, an independent expert opinion was sought from Dr Danny Sullivan, consultant forensic psychiatrist. Dr Sullivan both provided a report and gave evidence during the inquest.

7.3 These issues are considered in more detail below and some issues have been dealt with together for convenience.

8. Appropriateness of RIT management

8.1 In 2018, the relevant CSNSW policy with respect to management of an inmate on a RIT protocol was section 3.7 of the Custodial Operations Policy and Procedures (**COPP**) (Version 1.0) which deals with management of inmates at risk of self-harm or suicide. It relevantly provides for the constitution and membership of a RIT, the role and function of a RIT, and the process undertaken by a RIT in assessment of risk of suicide or self-harm.

8.2 Much of the evidence in the inquest focused on the RIT reviews of Tim that were conducted on 10 June 2018, 18 June 2018 and 2 July 2018.

8.3 On 10 June 2018, the RIT was comprised of: Senior Correctional Officer (**SCO**) Sam Izgun, Services & Programs Officer (**SAPO**) Deborah Moffitt, and RN Barbara Kiy. Evidence given by the RIT members may be relevantly summarised as follows:

(a) SCO Izgun gave evidence that he had little independent recollection of the review on 10 June 2018, but that the RIT considered it important that Tim had guaranteed his safety;

(b) Ms Moffitt gave evidence that Tim had impressed as "manipulative" and disclosed that he was "hiding out in the assessment cell", but that he denied any plan or intent to deliberately self-harm;

(c) Ms Moffitt went on to explain that her use of the word "manipulative" meant that Tim wanted to have his own cell, that he was fearful of other inmates, and that he may have been acting in way to cope, and to convince the RIT that he needed his own cell for his protection;

(d) RN Kiy gave evidence that whilst she did not want to make a judgement whether Tim was being manipulative or not, she noted that, in her experience, there are many manipulative inmates (who say inauthentic things to achieve a particular goal) on RIT management;

(e) RN Kiy also gave evidence that the RIT cleared Tim because he had presented similarly on other occasions and that he had denied thoughts of self-harm, leading to a decision to place him in a less restrictive environment.

8.4 On 18 June 2018, the RIT was comprised of: SCO Frank Cunningham, Ms Moffitt and RN Kiy. Evidence given by the RIT members on this date may be relevantly summarised as follows:

(a) SCO Cunningham gave evidence that he would not have been aware that Tim had reported auditory hallucinations and paranoia, that it was likely Tim would have been happy with achieving a goal of one-out cell placement, and that it may have been of importance that Tim had been receiving medication from 15 June 2018;

(b) RN Kiy gave evidence that Tim had denied thoughts of self-harm but had attempted to harm another person. Although this raised the possibility of Tim being psychotic, it was not possible to "lock every psychotic person away in a cell with a mattress and a toilet";

(c) RN Kiy also gave evidence that the plan formulated by the RIT was for Tim to be housed in a one-out cell within a busy Pod, pending review by a psychiatrist.

8.5 On 2 July 2018, the RIT was comprised of: SCO Cunningham, Ms Moffitt and RN Watson Zifamba. Evidence given by the RIT members on this date may be relevantly summarised as follows:

(a) SCO Cunningham gave evidence that apart from Tim's expressed desire to leave Darcy Pod, his mood was otherwise settled, good and forward-thinking;

(b) Ms Moffitt gave evidence that she considered Tim's behaviour to be manipulative as he wanted to be in a one-out cell, acknowledged that her reference in her case notes to Tim having convinced doctors "*he requires mental health coverage*" was poorly worded, and that she did not intend to convey that the psychiatric opinion was invalid, but that she was seeking signs of active psychosis;

(c) Ms Moffitt agreed that dismissive and disorganised behaviour, experiencing hallucinations and being withdrawn were indicators of risk, but explained that Tim was released from RIT management because he appeared dismissive and disinterested in engaging with the RIT (and had demonstrated similar behaviour previously), he showed no signs of auditory hallucinations, and the RIT took some reassurance that he would receive mental health "coverage" due to the scheduled transfer to Long Bay Hospital;

(d) RN Zifamba gave evidence that he considered Tim to be "*opinionated"* and "*entitled*", and that his behaviour was "*challenging*". RN Zifamba also said that Tim had denied thoughts of self-harm, that he had previously self-referred when he felt unsafe, that he would be supported by review by a mental health nurse and a psychiatrist, and therefore the RIT decide to give Tim "*the benefit of the doubt*".

8.6 In his report, Dr Sullivan expressed the view that it would have been more appropriate for Tim to remain under RIT management:

(a) on 10 June 2018 "*until there was greater confidence in the authenticity of his communications and better relational security derived from the [RIT] interviews*";

(b) on 18 June 2018 as the level of understanding of Tim's mental state, and "*staff engagement with him, remained poor*", and that continued RIT management would have "*ensured conjoint communication about and oversight of a prisoner who was struggling and whose disordered behaviour was not clearly understood*"; and

(c) on 2 July 2018, noting that by this stage Tim's mental health had deteriorated over the preceding six weeks with recurrent self-harm attempts, cell damage, a diagnosis of psychotic illness and erratic compliance with his medication regime which had been established less than three weeks earlier. In addition, Dr Sullivan considered that RIT management would have been appropriate until:

(i) there was an available bed in the MHSU;

(ii) Tim was transferred to Long Bay Mental Health Unit; or

(iii) Tim "*had engaged effectively and repeatedly in RIT interviews so that staff could be satisfied that this behaviour was more settled and predictable*".

8.7 Dr Sullivan also considered that the discharge plan on 2 July 2018 was appropriate as Tim was to remain in a high acuity area within Darcy Pod, pending transfer to the MHSU. It was also appropriate for Tim to remain in single cell placement (rather than an assessment cell) due to his psychosis and unpredictable behaviour. However, Dr Sullivan opined that it was not clear "*whether RIT management would have made a significant difference in regime or placement*".

8.8 Dr Sullivan readily acknowledged that placement of an inmate in a safety cell is a distressing event and one which causes a clinician to question the "*notion of what is therapeutic*", but that it is justified by the risk of self-harm or harm to others. Dr Sullivan explained:

> So ideally you - you place a person in a RIT cell only when you can find no practicable alternative which will reduce the risk, and you seek to remove a person from that cell as soon as you can be satisfied that the risk can sensibly be moderated by other interventions.
>
> And that usually involves a degree of trust that the patient is working with you, assurance that what they're telling you is authentic, or as far as you can determine is - is an accurate representation of their mental state, and that you have a plan. That going forward will ideally seek to address whatever factors have created the risk scenario, whether that's isolation from family, the particular placement, the need to treat a particular mental health disorder, and in some cases you might not have any specific mitigating strategies, but you might be satisfied that the person's risk can be managed in a mainstream or a non-at-risk setting.

8.9 Dr Sullivan also agreed in evidence that assessment of suicide risk at particular point in time (for example, during a RIT review) is a very challenging process in a correctional setting because:

(a) the custodial environment is not a therapeutic one;

(b) clinicians are required to assess a large number of people and their risk of suicide;

(c) a person's risk of suicide can be quite changeable from time to time;

(d) different clinicians might elicit different interactions from people, meaning that some inmates will interact better with some clinicians than others; and

(e) there are a range of unpredictable factors (such as gender, age, time of day, whether an inmate has eaten or not) which may influence the quality of the interaction and the assessment itself.

8.10 Dr Sullivan gave evidence that the main benefits in keeping Tim on RIT management on 10 June 2018, 18 June 2018 and 2 July 2018 were to:

(a) build rapport with him;

(b) allow recurrent review by a RIT that would have provided some stability in the context of Tim's "*tumultuous*" period in custody;

(c) keep Tim subject to a degree of mental health oversight and monitoring; and

(d) allow for ongoing assessment and interventions.

8.11 As to rapport building, Dr Sullivan explained that Tim's behaviour that was due to his mental illness, and instrumental behaviour that might have been done to achieve a particular purpose (such as a transfer out of Darcy Pod) can co-exist. In this context, Dr Sullivan acknowledged the difficulties in building rapport with Tim due to the custodial setting which made assessment more difficult, and that Tim may have been presenting a particular impression in order to be taken off RIT management.

8.12 Ultimately, Dr Sullivan explained the two separate processes involved in keeping an inmate under RIT management:

> One of them is an acute process which is the RIT process, and the other one is the longer trajectory of meeting a person's healthcare needs, and in particular mental healthcare needs while in prison. The RIT process is a short-term intervention for the period that a person remains at risk, and it's meant to mitigate the acute risk. For a person who's on chronic longer term risk status, you can't maintain them on RIT forever because it's inhumane and sooner or later, if a person continues to promise that they won't self-harm there will be a stage at which you will say, okay they can come off RIT now. The second aspect though is identifying, diagnosing, through continuing assessment, mental health disorders, or the - or situational stressors, and identifying how to meet those in ways which help a person to cope better during their imprisonment. So those are actually two separate processes. And of course you can be subject to both at the same time, but they really have a different time period in mind.

8.13 **Conclusions:** The evidence establishes that it would have been more appropriate for Tim to have remained under RIT management following the reviews on 10 June 2018, 18 June 2018 and 2 July 2018. This is because at the time of the reviews Tim had demonstrated limited engagement with the RIT members, meaning that understanding of his mental state and disordered behaviour was also limited, and the RIT members could have little confidence in the authenticity of what Tim was telling them. Remaining under RIT management would have allowed for Tim to be monitored and reviewed regularly, and for any ongoing interventions to be facilitated.

8.14 However, it is accepted that RIT members face unique challenges in assessing inmates in a custodial setting, and that a range of unpredictable factors may affect the quality of such assessments. In particular, it can be difficult to discern between instrumental and psychotic behaviour. Indeed, Dr Sullivan recognised that there were "*competing narratives*" in Tim's case. Notwithstanding these different narratives, Dr Sullivan considered that "*the management plan was clearly documented and adequate, involving ongoing medication, placement in a specialised unit to further assess and manage mental illness, and decisions made with consideration of risk*".

8.15 Further, the RIT process is a short-term intervention meant to mitigate acute risk rather than provide mental health care over a longer trajectory. In this regard, Dr Sullivan agreed that Tim could not be kept under RIT management indefinitely.

8.16 Finally, Dr Sullivan acknowledged that ongoing RIT management may not have made any material difference in regime or placement. Therefore, it is not possible to conclude whether ongoing RIT management after 2 July 2018 is likely to have materially altered subsequent events or averted Tim's tragic death five days later.

Proposed recommendation – additional funding for a mental health nurse on a RIT

8.17 Counsel Assisting submitted a recommendation ought to be made that Justice Health consider applying for additional funding to ensure that a mental health nurse is scheduled on RIT teams in circumstances where: (a) the risk to an inmate has a mental health component; and/or (b) an inmate's RIT status has changed four or more times within a period of a month.

8.18 It was submitted on behalf of Justice Health that it does not, in principle, oppose recommendations relating to further funding for increased clinical capacity. However, it was submitted that in the *Inquest into the death of Bailey Mackender*, a recommendation was made that Justice Health give consideration to developing a protocol to ensure that when a staff member participates in a RIT review meeting that member is, if available, a mental health nurse and if not, that the participating member has access and opportunity to consult with mental health staff either at the centre or via Remote Off-site After-Hours Medical Services (**ROAMS**).

8.19 This recommendation was implemented in the current Policy 1.380 *Clinical Care of People who are Suicidal*. It provides that a mental health nurse is to be made available where the patient for review has a major mental illness that is increasing the patient's risk. Where a primary health nurse is undertaking the RIT and requires advice in relation to the risk assessment and management processes they are able to either contact an on-site Custodial Mental Health clinician or contact ROAMS.

8.20 Having regard to the response by Justice Health to the earlier recommendation made, it is neither necessary or desirable to make, in essence, a duplicate recommendation in this inquest.

Proposed recommendation – inclusion of psychologist on RIT

8.21 It was submitted on behalf of Tim's family that a recommendation ought to be made that a psychologist be included as a member of any RIT. It is noted that a similar recommendation was made in the *Inquest into the death of Bailey Mackender*. The response to that recommendation by CSNSW in July 2022 was that it is not feasible to require a psychologist to be present at every RIT assessment as doing so would prevent an assessment from occurring if a psychologist was not available.

8.22 It was submitted on behalf of CSNSW in the present matter that, if available, CSNSW psychologists may sit on a RIT but this is subject to certain resourcing considerations:

(a) psychologists are responsible for both criminogenic and health-related matters, and moving psychologists away from those matters is likely to result in a reduction of contact with other inmates; and

(b) while assisting with acute mental health and self-harm is a very high priority, there are not sufficient psychologists to attend to very high priority matters as well as to sit on the numerous RIT reviews that take place daily across NSW.

8.23 The following changes since 2018 should also be noted:

(a) in February 2023, Justice Health recruited two clinicians to form a Suicide Prevention Outreach Team (**SPOT**). Patients are referred to SPOT where they are identified as being at risk of suicide. The service works closely with all Justice Health teams as well as CSNSW to ensure patients are receiving holistic care. The service supports patients that are experiencing suicidal thoughts or behaviours while in custody or transitioning back to the community; and

(b) Joint Complex Client meetings have been introduced as a weekly meeting at MRRC, involving Custodial Mental Health, Primary Health, CSNSW and Psychology to review patients who have been flagged for discussion.

8.24 Having regard to each of the above matters, it is neither necessary or desirable for any recommendation to be made.

9. Completion of mandatory training for RIT members

9.1 Section 3.7 of the COPP provides that:

(a) all CSNSW staff who are members of a RIT must complete the *Awareness of Managing At-Risk Offenders* (**AMARO**) online e-learning module; and

(b) all RIT Coordinators must also complete the 2-day Managing At-Risk Offenders (**MARO**) course at the Brush Farm Corrective Services Academy (**the Academy**).

9.2 The evidence demonstrated the following in relation to the relevant CSNSW staff:

(a) CSNSW training records indicated that SCO Cunningham had not completed the MARO course by 2018 (but that he subsequently completed it in April 2022). However, SCO Cunningham gave evidence that he had in fact completed this course, or at least what he considered to be an equivalent course as early as 1993. SCO Cunningham also gave evidence that he been a member of over 500 RITs, and had completed a 2 day course in suicide awareness training, and an online training course which contained components from the MARO course.

(b) In 2018, SCO Izgun had also not completed the MARO course but he gave evidence that he was enrolling himself to complete the course in April 2023.

(c) CSNSW training records indicated that Ms Moffitt had not completed the AMARO course by 2018. However, Ms Moffitt gave evidence that she completed the course in February 2023, that she had also completed other courses with components on risk and suicide, and that she had been a member of approximately 3000 RITs.

9.3 **Conclusions:** The evidence established that, as at 2018, SCO Izgun had not completed a mandatory training course, and that SCO Cunningham and Ms Moffit most likely (based on documented CSNSW records) had also not completed mandatory training courses. However, by 2018 SCO Cunningham and Ms Moffitt had considerable experience in participating in RITs, and had completed other training concerning matters relevant to their roles and responsibilities as members of a RIT. There is no evidence that non-completion of any mandatory training course by any of the CSNSW members of the RITs in June and July 2018 contributed to the adequacy of their assessment of Tim or materially affected the eventual outcome.

Proposed recommendation – training of CSNSW staff members

9.4 Counsel Assisting submitted that recommendations ought to be made that CSNSW ensure that no employee is scheduled on a RIT unless that employee has completed requisite training, and take steps to improve communication with relevant CSNSW employees to ensure that they are aware of the training they are required to complete to sit on a RIT, and consider the introduction of refresher training for RIT members.

9.5 Since July 2018, the COPP has been amended to require staff to ensure that their relevant RIT training has been completed or is up to date. Further, ISPs and RIT Management Plans have been amended to require staff to confirm in writing that training has been undertaken commensurate with their role on a RIT.

9.6 In addition, the MRRC has implemented a Local Operating Procedure (**LOP**) which requires that any staff member who sits on a RIT must be properly trained in accordance with the COPP. In essence, the LOP ensures that any supervisor in a RIT coordinator position and all SAPO rostered on a RIT have completed all training requirements, and that any CSNSW Officer or SAPO who has not completed such training is not to be rostered on a RIT.

9.7 Counsel for CSNSW submitted that the introduction of refresher training is supported and under consideration and that if a determination is made for graduates of the MARO course to receive refresher training on a 5-yearly basis, the Academy would have capacity to work towards that objective. Having regard to these submissions and the above matters, it is desirable to make the following recommendation.

9.8 **Recommendation:** I recommend that the Commissioner of Corrective Services New South Wales consider the introduction of, at a minimum, 5-yearly refresher training for all staff who are members of Risk Intervention Teams.

Proposed recommendation – RIT training topics

9.9 Counsel Assisting also submitted that CSNSW review present RIT training to ensure that the following topics are covered: (a) identifying and evaluating risk of suicide or self-harm; (b) how to adequately document decisions taken by a RIT; (c) procedures in place to facilitate communication with family; and (d) best practice in information-sharing procedures.

9.10 Counsel for CSNSW submitted that current RIT training regarding identifying and evaluating the risk of suicide and self-harm is already covered by both the AMARO and MARO courses. In particular, the MARO course requires participants to:

(a) work through case studies that involve role-play activities centred around identifying and evaluating risk factors;

(b) adequately complete the relevant RIT forms (such as a MNF and ISP) for documenting decisions;

(c) enter a case note on the Offender Integrated Management System (OIMS) for each RIT meeting, which relevantly covers observations of the inmate's physical presentation, attitude and behaviour, issues or concerns raised by the inmate, and next steps or actions required to be taken;

(d) discuss and consider diversionary activities which includes contact with the inmate's family, and discuss appropriate referrals to assist with contacting family; and

(e) discuss with other members of the RIT any relevant information/updates their specific discipline can provide.

9.11 Having regard to the content of both the MARO and AMARO course, it is neither necessary or desirable to make any recommendation.

Proposed recommendations – training for Justice Health nurses

9.12 Counsel Assisting and the legal representatives for Tim's family submitted that a recommendation ought to be made that Justice Health consider the introduction of mandatory training for all nurses who participate in a RIT on the following topics: (a) relevant Justice Health and CSNSW polices; (b) identifying and evaluating risk of suicide or self-harm; (c) how to adequately document decisions taken by a RIT; (d) procedures in place to facilitate communication with family; and (e) best practice in information-sharing procedures.

9.13 Justice Health has a number of existing training which addresses some of the matters referred to above:

(a) *Suicide in Custody* training is mandatory for all nursing staff who, relevantly, work in correctional centres, and training covers topics such as identifying suicide risk, risk assessment, management and documentation. It also describes the context of suicide in custody and refers to the National and State responses to suicide prevention;

(b) *Clinical Care of People Who May Be Suicidal* training is aimed at the identification of suicide risk, risk assessment and documentation. It is targeted at primary care nurses;

(c) *Introduction to Mental Health* training aims to develop skills in mental health examination and the identification of certain mental health conditions.

9.14 Training regarding communication with families of inmate patients is discussed in more detail below.

9.15 However, having regard to the content of existing training courses for Justice Health nurses, it is neither necessary or desirable to make any recommendation.

9.16 Counsel Assisting also submitted that a recommendation ought to be made that Justice Health ensure that no employee is scheduled on a RIT unless they have completed the requisite training.

9.17 As noted above, *Suicide in Custody* training is mandatory for all nursing staff except those who have worked in a mental health role in the previous 3 years, or those with postgraduate education in the previous 5 years. Counsel for Justice Health submitted that his is because such content would already be familiar to those nurses.

9.18 It appears then all Justice Health staff will have completed requisite training, or have relevant experience, prior to being a member of a RIT. Therefore, it is neither necessary or desirable for a recommendation to be made.

9.19 Counsel Assisting also submitted that consideration be given to the potential benefit of holding joint training sessions for CSNSW and Justice Health employees who are scheduled to sit on a RIT.

9.20 Shona Cuthbertson, Service Director Custodial Mental Health for Justice Health, explained that Justice Health and CSNSW have previously discussed consolidating RIT training to ensure consistency of practice. The two agencies have been working toward trialling joint RIT training courses at the MRRC, but there have been some delays in implementation. A training proposal has been developed by Justice Health's Project Lead and provided to CSNSW for review.

9.21 Having regard to the work that is already being done by both Justice Health and CSNSW to implement joint RIT training courses, it is neither necessary or desirable for a recommendation to be made.

10. Suitability of psychiatric assessments

10.1 Dr Sullivan noted that on 2 July 2018, Dr Wade's assessment of Tim was brief and limited due to his lack of engagement. However, Dr Wade recognised that Tim was still unwell and likely to have ongoing psychotic symptoms and changeable behaviour. Dr Wade noted that Tim was compliant with olanzapine and considered that he was able to be managed in the MHSU.

10.2 Dr Sullivan explained that "*unless there was strong evidence of a sustained depressive or manic component*" to Tim's presentation, "*few psychiatrists would have also considered antidepressant or mood stabilising medication*". Dr Sullivan considered that quetiapine and olanzapine were appropriate medications, and that there was an effective dose of olanzapine. Overall, Dr Sullivan opined that Dr Wade's assessment was adequate and appropriate, and that her impression "*was sufficient to inform an opinion about where [Tim] could be managed in the correctional system*".

10.3 **Conclusions:** The psychiatric assessment conducted by Dr Wade on 2 July 2018 was adequate and appropriate. Although the assessment was limited to due Tim's lack of engagement, Dr Wade had available to her sufficient information to form an opinion regarding Tim's management.

11. Wait times for mental health review

11.1 On 23 May 2018, Tim was placed on a waitlist to see a mental health nurse with a non-urgent priority 3 that required him to be seen within 3 months. He was seen 10 days later, on 2 June 2018, by a RN.

11.2 On 28 May 2018, Tim was placed on a waitlist to see a psychiatrist with semi-urgent priority 2, requiring him to be seen within 14 days. On 15 June 2018 (18 days later), Tim was reviewed by Dr Hearps. No notes were recorded from this review, apart from the prescription of medication. On 28 June 2018 (31 days after referral), Dr Hearps reviewed Tim again.

11.3 In evidence, Dr Sarah-Jane Spencer, Clinical Director, Custodial Mental Health, expressed this view as to the likely reason for the delay in Tim being reviewed by a psychiatrist:

> I imagine that it would have been a product of the fact that there were many patients waiting to see a psychiatrist and, combined with the fact that there are small windows in which you are able to see patients because they are locked in so early, that there is limited opportunity for any clinician to see patients who need to be seen, so, unfortunately, there are occasions when the guideline of when you're trying to see a patient, we're not able to keep to that for a variety of factors and there are also days when all patients are locked in, you're not able to see - you're not able to see anyone as well. I don't know exactly what happened in this case, but I imagine it was probably a combination of those factors.

11.4 In submissions, Counsel for Justice Health accepted that "*it would have been preferable for Tim to have been seen by a psychiatrist sooner*".

11.5 **Conclusions:** The time taken for Tim to be reviewed by a psychiatrist in May and June 2018 did not conform with defined timeframes for such reviews to occur. The precise reason for this delay cannot be discerned from the available evidence, although it is most likely that everyday operations within the custodial environment and the ratio of available psychiatrists to the number of inmates scheduled for review were contributing factors. As acknowledged by Justice Health, best clinical practice suggests that Tim ought to have been reviewed within the specified timeframes.

12. Adequacy of review after 2 July 2018

12.1 At the time of Dr Wade's assessment on 2 July 2018, she intended for Tim to be reviewed by a nurse in 3 days, and by a psychiatrist in 7 days. Although Tim was seen twice daily by a nurse between 2 and 7 July 2018 for medication rounds, no formal documented assessments of Tim were performed during this period. Further, no notes were recorded of any observations made of Tim during this period.

12.2 Although the psychiatrist appointment was entered into the Patient Administration System, the nurse appointment was not. Dr Spencer gave evidence as to reason for this:

> I think, there was a misunderstanding between the nursing staff, so the nurses outside of any recommendation from a psychiatrist, if they had seen a patient, they would organise their own waiting list for follow-up. So, there wasn't a process in place for if someone other than a nurse recommended follow-up who was going to action that follow-up. So, someone did action the psychiatrist recommendation for psychiatry follow-up, but no one actioned the recommendation for nursing follow-up.
> […]
> [F]eedback at the time was that they weren't clear on who was meant to do it, so a decision was made to move all of that to an administrative role and the admin role would ensure any follow-up was put into PAS, which is now what happens.

12.3 Dr Spencer went on to explain the steps taken to ameliorate the above issues:

> So, there is a tracker sheet which has been designed to prompt the medics to answer specific questions to make it more uniform across the board and clearer. That's the current process.
> […]
> So, this tracker has been used for some time now which the idea being that there is prompts for the psychiatrist and that then this tracker sheet goes to a specific admin, administrative person who will action anything that's on the sheet. So, it's quite clear whose responsibility it is and what information is required from the psychiatrist and that's been audited both at that time and it's ongoing and the audit results are fed back to our monthly clinical governance meeting.

12.4 Finally, Dr Spencer gave evidence that since 2020, monthly audits have been conducted to ensure that the tracker system described above has been utilised, with the results consistently demonstrating that "*the process has made a difference*".

12.5 Counsel for Justice Health acknowledged that it is "*regrettable*" that Tim was not reviewed between 2 and 7 July 2018, and that this "*should have occurred*".

12.6 Dr Sullivan noted that one benefit of keeping Tim under RIT management would have been that it ensured he was reviewed by a mental health clinician every two days. However, Dr Sullivan went on to express this view:

> However, it is not clear that [Tim's] suicide would have been prevented, given that his previous self-harm and assault on a cellmate had not been predicted by his earlier assurances or specific features of his mental state.

12.7 **Conclusions:** Tim was not adequately reviewed in the period between 2 and 7 July 2018. Indeed, despite Dr Wade's plan for Tim to be reviewed by both a mental health nurse and a psychiatrist, he was not in fact reviewed at all. Given the opinion expressed by Dr Sullivan regarding the need for recurrent monitoring of Tim, the absence of any review for a five day period was not consistent with optimal or intended management of Tim. However, it is not clear whether such review might have prompted any intervention or materially altered the eventual outcome.

12.8 The absence of any review was a result of administrative processes at the time being insufficiently robust and repeatable. There was a fundamental misunderstanding as to who held the responsibility of actioning any follow-up recommended by a psychiatrist. However, since 2018 new processes have been introduced to provide greater clarity regarding administrative responsibilities for follow-up of inmate patients, with regular audits demonstrating improved outcomes.

Proposed recommendations – follow-up after discharge from RIT management

12.9 Counsel for Ms Moffitt submitted that whenever a patient is discharged from RIT management, follow-up ought to be provided by a psychologist or mental health nurse.

12.10 Section 3.7 of the COPP already provides that:

> Even when the RIT assesses no current risk of suicide or self-harm, some inmates who are discharged from a RIT Management Plan will require ongoing management strategies and coordinated provision and review of services and programs to minimise their longer-term risk of suicide or self-harm.
> […]
> The RIT Discharge Plan should give recommendations to supplement normal management processes with specific conditions around referred services to be provided.
>
> The RIT Discharge Plan must ensure that the risk factors that precipitated the RIT are addressed through appropriate referrals to CSNSW services and programs and JH&FMHN.

12.11 It was submitted on behalf of Justice Health that requiring every person to be reviewed by a specialist such a psychologist following discharge from RIT management would place an undue burden on those resources, and would often not be required. Instead, it was submitted that it is preferable to prepare discharge plans according to the individual needs of an inmate patient.

12.12 It is evident that the COPP already provides for an inmate patient to be referred to appropriate services and programs following discharge from RIT management, and that a blanket requirement for follow up by a psychologist or mental health nurse would be impractical and not always warranted. Therefore, it is neither necessary or desirable for a recommendation to be made.

Proposed recommendations – application for additional funding

12.13 Counsel Assisting submitted that a recommendation ought to be made to both Justice Health and CSNSW that strong consideration be given to applying for additional funding for the purpose of increasing the capacity of the Mental Health Screening Unit to reduce the time that inmates spend on waitlists, for both safe and acute cells.

12.14 It was also submitted that a recommendation be made that strong consideration be given to applying for additional funding for the purpose of increasing the capacity of the Mental Health Screening Unit to reduce the time that inmates spend on waitlists, for both safe and acute cells.

12.15 It was submitted on behalf of both CSNSW and Justice Health that such recommendations are supported in principle. It should be noted that In April 2021, Justice Health NSW submitted a proposal to Ministry of Health, seeking support and funding for "*A Care Pathways Model for Custodial Mental Health – Renewed model of care and implementation plan* (**Model of Care**).

12.16 Whilst the proposal is not specific to the MHSU, Ms Cuthbertson explained that the Model of Care aims to standardise procedures at the Screening, Triage, Assessment, Intervention and Reintegration points of care to reliably direct care. By ensuring screening, triage and assessment processes are empirically informed and standardised, the right patients can be identified, referred and prioritised more appropriately.

12.17 To date, Justice Health NSW has not received any funding for the Model of Care. However, in 2021, Justice Health NSW internally reallocated funding from another service area to commence the first stage of the Model of Care, staffing an additional 150 mental health step down/up beds across the Long Bay Complex.

12.18 Counsel for Justice Health noted that funding for increased clinical capacity is a topic which has been previously considered in other inquests since 2021. This had resulted in various recommendations for Justice Health to use findings to advance the position before the Ministry of Health that the Model of Care be implemented and that copies of findings be forwarded to the Ministry of Health for consideration. It was submitted on behalf of Justice Health that it will continue to advocate for more funding to implement the Model of Care.

12.19 The power available pursuant to section 81 of the Act is not routinely used in relation to matters of public funding. Government agencies and organisations are frequently regarded as parties of sufficient interest in many inquests, particularly those pursuant to section 23 of the Act. Issues of resourcing, and consequently funding, often feature in such inquests. However, it is well-recognised that issues relating to public funding are complex and multi-faceted. Making a recommendation about the allocation of funding to one area of government would necessarily have implications for other areas of government. Inquests are not typically informed about such matters.

12.20 Having regard to the above, and given that Justice Health has advocated, and will continue to advocate, for funding to implement the Model of Care, it is neither necessary or desirable for any recommendation to be made.

13. Management of prescription medication

13.1 Tim was prescribed quetiapine (25mg for 2 days and 50mg for 2 days) and diazepam on 4 April 2018, although there is no evidence that the medication was dispensed. On review at Wyong Hospital, Tim was given 50mg of quetiapine. At his RSA, Tim did not report that he had any mental health issues or took any medication.

13.2 Justice Health staff therefore did not become aware of Tim's previous prescriptions until the Wyong Hospital medical records were obtained on 24 May 2018. As a result, Tim was scheduled for review by a mental health nurse on 2 June 2018.

13.3 Dr Sullivan gave this evidence regarding Tim's quetiapine prescription:

> Doses of 25, 50 or 100 mg [of quetiapine] really are prescribed for sedation, but not for antipsychotic effect. I don't think any psychiatrist would think that a dose less than 300 or 400 mg per day would be effective for a person who was psychotic. And the maximum recommended dose is 1,200 mg per day. So the preceding doses that Tim had been prescribed were not effective for a psychotic illness. […]
>
> But quetiapine 25 mg is not an effective antipsychotic dose. It might result in a little bit of sedation overnight, but I wouldn't expect it to be effective for schizophrenia, and all of the evidence bases would support that that is sub-therapeutic dose.

13.4 Dr Spencer explained that the low dose of quetiapine 25mg in this way:

> So the Quetiapine is - is a very - is a very small dose, that is, not a dose that would be effective for either bipolar disorder which is what it can be used for or for schizophrenia. So, the maximum dose is 800 milligrams a day and, normally, patients who have a major mental illness are treated with no less than, sort of 400 milligrams a day. So, 25 milligrams of Quetiapine is often used by general practitioners, in particular, in the community, for a sort of off-label to help someone with their sleep. So, I think that that would have been taken into account, though I can't comment for the clinicians, in particular, but that is not a dose of a medication that would indicate that someone had a major mental illness.

13.5 On 6 June 2018 a telephone order for 25mg quetiapine was obtained. This was increased to 200mg on 15 June 2018. After Tim was reviewed by Dr Farrar, olanzapine was charted for Tim, and he remained on this medication until he refused it on 7 July 2018. Dr Sullivan opined that quetiapine and olanzapine were appropriate medications for Tim and that the dose of quetiapine "*from late June into July was an effective dose*".

13.6 **Conclusions:** Upon reception into custody, Justice Health staff were unaware of Tim's medication history within the community. This did not become apparent until 24 May 2018. The evidence established that the small dose of quetiapine that Tim had been prescribed in the community would be considered to assist with sleeping, and not indicate that Tim had a major mental illness. Accordingly, Tim's medication history did not suggest that a review by a mental health nurse prior to 2 June 2018, and a review by a psychiatrist prior to 15 June 2018 was indicated.

13.7 Following psychiatric review, Tim was appropriately prescribed olanzapine in addition to quetiapine, both at effective doses. There is no evidence to suggest that the delay in commencing antipsychotic medication had any bearing on subsequent events.

14. Communication with Tim's family

14.1 A matter of central importance to Tim's family during the inquest concerns the extent to which they were able to communicate their concerns for Tim, and obtain information regarding his management and well-being. In her statement, Mrs Garner said that she "*continually called*" the MRRC to express her concerns that Tim was acutely unwell, not taking his medication and not being treated properly.

14.2 As to the issue of facilitating communication with family, training regarding such communication and use of consent forms, entitled *You Don't Need Consent to Listen*, was introduced in response to a recommendation made in the *Inquest into the death of Bailey Mackender* in December 2021. The program is designed to:

(a) educate Justice Health clinical and administrative staff on current policy and procedure regarding communication with families and carers;

(b) train clinical and administrative staff in communicating with families and carers; and

(c) train clinical and administrative staff in the use of current consent forms.

14.3 Further, in March 2023, Justice Health initiated a *Family and Carer Engagement (**FACE**) Clinical Redesign Project* to facilitate collaboration and enable meaningful partnerships between Justice Health and the families and carers of adult patients in custodial care. The Project completed its diagnostic phase in May 2023, and moved into the solutions phase by July 2023 with work commenced on the creation of singular point of contact in the form of a Virtual Hub staffed by members from the Client Liaison Team and Clinical Team (Nursing).

14.4 In addition, Justice Health has an existing *Working with Families and Carers Policy 1.434* which provides guidance to Justice Health staff in their work with families and carers of patients with a diagnosed mental illness. Relevantly, the policy explicitly draws attention to the critical role that kinship and family structures hold for First Nations patients and provides links to other policy and resources for First Nations carers.

14.5 **Conclusions:** The challenges encountered by Michelle in seeking to impart and obtain information regarding Timothy's well-being would no doubt have been distressing. However, since 2018, Justice Health has taken steps to facilitate collaboration between its staff and the families of inmate patients to assist in the management of such patients. Relevantly, there is specific guidance regarding communication involving those patients with a diagnosed mental illness and First Nations patients.

Proposed recommendations – Mental Health Line and Family Handbook

14.6 The Mental Health Line has been operating since 2001 and its contact details are displayed prominently on the Justice Health and CSNSW websites. In addition, the CSNSW Family Handbook, which is available to families, and also available on its website, refers to the Mental Health Line.

14.7 It was submitted on behalf of Tim's family that senior next of kin should be informed of the Mental Health Line number and given a physical copy of the CSNSW Family Handbook when a loved one enters custody because, it was submitted, "*not all families have the luxury to be able to access the internet or have computers to view websites*", and a copy of a brochure on the Mental Health Line be provided to families on reception.

14.8 It is evident that information regarding the Mental Health Line and the Family Handbook is publicly available and, in the case of the Mental Health Line, available for quite some time. The legal representative for Tim's family did not seek to explore accessibility to such information in evidence during the inquest. Therefore, it is not known whether such a recommendation is practical or capable of implementation. As an informed conclusion cannot be reached on this issue, it is neither necessary or desirable for a recommendation to be made.

Proposed recommendations – consent form

14.9 It was submitted on behalf of Tim's family that a recommendation ought to be made that at reception, patients should be asked to sign a consent form permitting contact with their family about mental health issues.

14.10 Justice Health *Policy 4.030 Requesting and Disclosing Health Information* highlights the privacy implications that attend consideration of such a recommendation. Section 3.2 notes that general enquiries from a patient's family, carer, significant other or legal representative are sometimes made directly to a health centre or inpatient ward, but that health information must not be provided without the patient's written consent. Further, a Justice Health staff member responding to an enquiry must:

(a) advise the enquirer that detailed health information cannot be provided without the patient's consent;

(b) offer to ask the patient to telephone them so their questions can be answered directly by the patient; and

(c) if the enquirer requires detailed health information, advise the enquirer to contact the Client Liaison Officer who will arrange for a *Consent to Liaise* form to be completed.

14.11 It is evident that privacy considerations attend the issue of seeking automatic disclosure of an inmate patient's health information upon reception into custody. It also presumes that the need for an inmate to receive mental health support will be apparent at the time of reception. Existing policies already address the issue of information sharing by direct communication from an inmate

patient to their family or loved ones, and seeking appropriate and informed consent from a patient before health information is shared.

14.12 Having regard to the above matters, it is neither necessary or desirable for a recommendation to be made.

15. Other proposed recommendations

15.1 In her statement, Michelle said that whilst travelling from the Central Coast to Sydney to identify Tim, she received a call from CSNSW informing her that Tim had already been identified by a CSNSW officer. As a result, Michelle was not given an opportunity to see Tim or identify him until she subsequently attended a funeral home.

15.2 Adam Wilkinson, Governor of the MRRC, gave the following evidence on this issue:

> [I]n 2018 and as well as now, I'm not – I can't imagine or – or remember a – a policy where Corrective Services staff would actually identify the body of a deceased at all. I – I can't explain – explain that, and from our point of view – obviously, the – the area's secured as a crime scene. Police are called. Forensic investigations occur. Police release the – the – the crime scene, and then the government contractors come and pick them up. And then that, pretty much, is the end for Corrective Services. The police notify next of kin and whatever processes exist for police about identifying a deceased is in place.

15.3 Governor Wilkinson went on to explain that no internal policy exists within CSNSW for any staff member to identify a deceased person, and that he is unaware of this happening in Tim's case.

15.4 It was submitted on behalf of Tim's family that "*a clearer process and formal policy by and between Corrective Services and NSW Police is required to ensure that senior next of kin are given the opportunity to identify the bodies of those who died in custody*".

15.5 The available evidence does not establish a sufficient basis for such a recommendation to be made. The NSW Police Force were not a party to the inquest and the circumstances in which Michelle was advised that identification of Tim had already occurred are unclear. It is therefore neither necessary or desirable for a recommendation to be made.

15.6 It was also submitted on behalf of Tim's family that "*inmates who have a prior history of coming on and off RITs should never be housed in cells with hanging points*". This issue was also not specifically explored in evidence during the inquest. However, Terrence Murrell, CSNSW General Manager, Statewide Operations, provided a statement in which he explained that the MRRC has approximately 580 cells with mounted sprinklers which are concealed within the ceiling slab and are not flush against ceiling (such as the cell that Tim was housed in on 7 July 2018). Mr Murrell explained that there are challenges with improving cell architecture due to substantial cost implications and older facilities such as the MRRC. However, Mr Murrell explained that "*CSNSW will continue to consider alternative mounted sprinklers and designs for cell and accommodation areas*".

15.7 By way of update, Governor Wilkinson explained in evidence:

> We have engaged, as part of a larger program across Corrective Services to reduce obvious hanging points in cells. There's a lot of bed scopes to be done at the MRRC and that works is currently undergoing – ongoing, sorry. So that's inclusive of modification of cell furniture, installation of fixed TVs, things like that, to reduce, one, obvious hanging points and also to make them not as stark as they have to be to be able to manage people who are in crisis.

15.8 Governor Wilkinson gave evidence about O-Block, a new facility at the MRRC which has 55 camera cells, built to the latest specifications of reduced hanging points, and assessment and transition cells. As at February 2023, a high proportion (approximately 75%) of inmates under RIT management are housed in O-Block. The remaining percentage of RIT inmates are still housed in Darcy Pod, although it is the intention of CSNSW to refurbish Darcy to the same standards that exist in O-Block, including by reducing the possibility of sprinklers being used as hanging points. Governor Wilkinson gave evidence that the project was about 50% complete with each remaining pod refurbishment taking about 14 weeks, depending on available resourcing.

15.9 It was submitted on behalf of CSNSW that it supports, in principle, a recommendation that that by the end of 2024, all inmates subject to RIT management are housed in O-Block or a refurbished cell in Darcy Pod. Having regard to this and the above matters, it is desirable to make the following recommendation.

15.10 **Recommendation:** I recommend that the Commissioner of Corrective Services New South Wales continue to monitor the progress of refurbishments at the Metropolitan Remand & Reception Centre with the aim of ensuring that all inmates subject to Risk Intervention Team management are housed in O-Block or a refurbished cell in Darcy Pod by the end of 2024.

16. Findings

16.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Dr Claire Palmer, Counsel Assisting, and her instructing solicitors, Mr Luke Sampson and Mr James Pender from the Crown Solicitor's Office. I acknowledge the assistance that they have provided throughout the coronial investigation, and the sensitivity and empathy that they have shown during all stages of the coronial process.

16.2 I also thank Detective Senior Constable Alex Cabrera for his role in the police investigation and for compiling the initial brief of evidence.

16.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Timothy Garner.

Date of death

Timothy died on 7 July 2018.

Place of death

Timothy died, whilst in lawful custody, at the Metropolitan Remand & Reception Centre, Silverwater NSW 2128.

Cause of death

The cause of Timothy's death was hanging.

Manner of death

Timothy died as a result of actions taken by him with the intention of ending his life.

16.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Tim's family, and in particular, Michelle and Tim's daughters, his friends and loved ones for their most tragic loss.

16.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
1 February 2024
Coroners Court of New South Wales