STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of WM
Hearing Dates:	20 October 2023
Date of Findings:	6 March 2024
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File Number:	2020/00103021
Representation:	Mr D Welsh, Coronial Advocate Assisting the Coroner Mr V Musico for the Commissioner of Corrective Services, New South Wales Ms N Szulgit for Justice Health and Forensic Mental Health Network
Findings	WM died between 2 – 3 April 2020 at Lithgow Correctional Centre, 596 Great Western Highway, Marrangaroo. The cause of WM's death was in keeping with hanging. WM died from self-inflicted injuries, whilst in lawful custody serving a sentence of imprisonment.
Non-publication order	See Annexure A

1. Introduction

1.1 At the time of his death, Mr WM was 59 years of age and was in lawful custody, serving a sentence of imprisonment.

1.2 WM had a medical history which was significant for depression, anxiety, hypertension and seizures. He had a history of attempting self-harm in custody in 2010.

1.3 WM commenced serving his prison sentence on 20 May 2010.

1.4 On 3 April 2020, he did not present for the morning inmate roll call and was located in his cell hanging from a hand-crafted ligature which was placed around his neck and fastened to a metal grating located above the rear door of his cell.

1.5 The identity of WM and the location and time of his death are not in issue. This inquest has focused on the manner and cause of his death.

1.6 WM's brother, Mr BM has been present during these proceedings and has been in contact with the Coronial Advocate assisting prior to these proceedings. I would like to express my condolences to WM's family. I hope that WM's family have found some comfort in the careful examination of the circumstances surrounding his death.

2. The legislative requirement for an Inquest

2.1 Pursuant to the Coroner's Act 2009 ("the Act"), a Coroner is required to investigate all reportable deaths to determine the identity of the person that has died, when and where they died, and the cause and manner of their death.

2.2 A person can be detained in lawful custody either as a result of the refusal of bail pending the determination of alleged criminal charges, or as a sentenced prisoner after conviction. Section 23 of "the Act" requires the Court undertake a mandatory inquest when a person dies within a custodial setting, to ensure that a person deprived of their liberty, is adequately cared for by the State within that custodial setting.

2.3 The coronial investigation and inquest provides an independent inquiry into the circumstances surrounding a person's death in custody to assess issues of accountability, transparency and to ensure that the State has discharged its duty of care to an individual.

2.4 During these proceedings, evidence was received in the form of statements and other documentation, tendered in Court, and admitted into evidence. In addition, oral evidence was received from the officer in charge of the investigation, Detective Senior Constable Andrew Cole. Mr BM provided an oral statement on behalf of his family.

2.5 All material placed before the Court has been thoroughly reviewed and considered.

3. **WM's life**

3.1 WM was born on 21 September 1960 in Pennsylvania in the United States of America. He lived in the USA for most of his life. He served in the United States Marine Corp from 1978 until 1984. His postings included attending the Marine Security Guard School in 1982 and serving as a marine security guard in the US embassies in Argentina and China. He also served in the National Guard and the United States Air Force.

3.2 WM married in 1990. One child was born to this relationship. The couple divorced in 1996.

3.3 WM attended a nursing course in 1993 and graduated in 1996. He worked with the Health Care Rehabilitation Centre in Texas.

3.4 He commenced a relationship with his second wife in 2007 in Vietnam. WM suffered a significant head injury in a traffic accident in Vietnam in 2008 and was hospitalised and a right parietal craniotomy was performed. He was married on 13 October 2008.

3.5 On 4 February 2009, WM applied for a business long-stay temporary visa, also known as a 457 visa, with the Department of Health NSW as his approved nominee. The 457 visa was granted on 19 February 2009 and was valid for a period of four years. WM arrived in Australia in 2009 and commenced employment as a nurse at the Royal North Shore Hospital.

3.6 WM is believed to have had a minor criminal history in the USA and was previously a defendant in a restraining/protection order enforced for the protection of a female. He had no known criminal antecedents in Australia.

3.7 On 20 May 2010, WM was charged with murder. He was subsequently found guilty of the charge by a jury on 14 November 2011. On 9 March 2012, he was sentenced to a term of imprisonment for life.

3.8 WM appealed his conviction and sentence before the Court of Criminal Appeal. On 9 July 2015, his appeals were dismissed.

4. **WM's custodial history**

4.1 During his incarceration, WM was an inmate at several correctional centres in New South Wales.

4.2 He was classified as a high security inmate based on his sentence of life imprisonment. As such, he was required to be housed in high security correctional centres. He also received a classification as an extreme high

risk security inmate in relation to escorts which included an escort between correctional centres, court complexes and hospitals.

4.3 On 11 December 2010, WM is reported to have attempted self-harm at the Parklea Correctional Centre. He was located by Corrective Services Officers lying on the floor of his cell with wounds to both sides of his neck and both wrists. His injuries resulted in a significant loss of blood, which resulted in him experiencing a cardiac arrest. He was transported to hospital and eventually made a full recovery. NSW Police investigated the event and concluded that WM had used a razor blade to inflict the wounds to his neck and wrists.

4.4 In response to this attempt at self-harm, WM was housed in the Acute Crisis Management Unit for approximately three years. An inmate assessed for inclusion within the Acute Crisis Management Unit is placed under constant CCTV surveillance and is subjected to the supervision of the Corrective Services Risk Intervention Team (RIC). In September 2013, the RIC assessed that WM was suitable to be returned to the mainstream gaol population.

4.5 On 12 March 2020, WM complained of chest pain. Corrective Services believed that he was feigning his symptoms and raised concerns that he may attempt to escape his lawful custody whilst being transported to hospital or abscond as a patient. He was treated at Lithgow Hospital under the guard of corrections officers and did not make any attempt to escape.

4.6 On his return to Lithgow Correctional Centre he was placed on a segregation order. As a result, he was placed in the segregation unit as a sole inmate in his cell until the circumstances surrounding his recent transfer to Lithgow Hospital could be further investigated. As an inmate in the segregation unit, he was denied any direct contact with other inmates and was secured in his cell for 22 hours per day. He was permitted two hours of exercise in the exercise yard adjacent to his cell. WM remained in the segregation unit until his death.

4.7 WM had been consulting a psychiatrist during this time in custody. He was receiving a number of medications for his diagnosed depression and anxiety, including Mirtazapine. He was also prescribed Metoprolol and Lercardipine for hypertension and carbamazepine for seizures.

4.8 He last saw his psychiatrist in custody on 6 March 2020. He was scheduled to have further appointments with his psychiatrist on 20 April, 4 May and 8 June 2020. He had also seen the Mental Health nurse consultant on 24 March 2020.

4.9 On 6 March 2020, WM indicated to his psychiatrist that he was experiencing insomnia and had previously been prescribed mirtazapine and had been provided with care plans to assist with managing his symptoms, with limited success. He spoke to his psychiatrist about

government conspiracies, and they discussed trialling antipsychotic medications which he declined.

5. **Events on 2 April 2020**

5.1 On 2 April 2020, the Segregation Committee determined that WM's segregation order should be revoked and that he should be permitted to return to the mainstream prison population.

5.1 On 2 April 2020, as a result of that determination, the Functional Manager of Accommodation, Ms Thompson attended on WM in his cell and informed him of the Committee's decision to revoke the segregation order. WM responded with the comment, "That's good news." WM then spoke about his concerns relating to COVID 19 and how the Canadian health system and other countries were dealing with the virus. He then indicated to Ms Thompson that he was relieved to be returning to Unit 6.1 within the gaol and Ms Thompson left his cell.

5.2 Ms Thompson then spoke with the Acting Senior Correctives Officer from Unit 6 and arrangements were made for a dual occupancy cell to be converted to a single occupancy cell to house WM for his transfer the following day.

5.3 At 3.34pm on 2 April 2020, WM made a call on the intercom system, requesting that he be allowed to speak to the "three striper" that he had spoke to earlier in the day. It is assumed that he was referring to Ms Thompson. WM stated that he wished to speak about being taken out of segregation and "sending me back to six, that doesn't solve my problem." Ms Thompson was not advised of this conversation, however she opined that he was referring to his "dislike of Unit 6.2 within Lithgow Correctional Centre, a centre that in WM's opinion housed inmates that he did not find as hospitable as those in Unit 6.1. This was the last use of the intercom by WM.

5.4 At 7.05pm on 2 April 2020, a registered nurse, Ms Taylor entered WM's cell, together with First Class Correctional Officer PH. (Peter Hardie). At this time, WM was administered his usual daily dosages of Mirtazapine, Metoprolol, Carbamazepine and Lercardipine. WM did not say much during this visit and did not refer to any desire to self-harm.

6. **Events on 3 April 2020**

6.1 On 3 April 2020, a First Class Correctional Officer was tasked to perform the morning roll call in Unit 5.2 at Lithgow Correctional Centre. At 8.22am, the officer opened the inspection door to cell 245, which housed WM. The officer observed WM at the rear of his cell and hanging from a ligature around his neck. The officer called for assistance and staff entered the cell and cut the ligature.

6.2 CPR was commenced by the officers and continued until nursing staff arrived at the cell and it was confirmed that WM was deceased. NSW paramedics attended the scene and confirmed that WM was deceased.

6.3 WM's cell was declared a crime scene and NSW Police attended, as requested. Police confirmed that the ligature appeared to have been fashioned from torn bed sheets and attached to the metal grating above the cell door. No obvious suicide note was located.

6.4 A folder was located on the top bunk bed within the cell which appeared to house WM's personal property.

6.5 A note was located which stated the following:
"[redacted], if you're reading this you're too late. I contacted the embassy and told them I'd post the documents on the internet. Previously I contacted the [word unknown] and offered all info to them but they acted like they didn't believe me. One of them got here first and they probably weren't happy. Give my love to [redacted] and my little girl. Semper Fi."

6.6 Detective Senior Constable Andrew Cole, the officer in charge of the investigation, commented that "While the exact reason for this note being written by the deceased is unknown, it is not believed to have been a suicide note." He further noted that "The term Semper Fi, which is written at the bottom of the note is a Latin term meaning always faithful, or always loyal." This phrase is used by the US Marine Corps as their slogan. It is believed that the deceased had previously served in the US Marine Corps.

6.7 Police reviewed the CCTV for Unit 5.2 which covered the front of the cell housing WM, being cell 245. No-one was shown to have entered his cell after he was administered his prescribed medications at 7.05pm on 2 April 2020 until he was discovered at 8.22am on 3 April 2020. Police also reviewed the CCTV of the exercise yard attached to the rear of his cell. No persons were shown to have entered or exited his exercise yard during the relevant 24 hours of recorded footage that was reviewed by police.

7. **Custody telephone records**

7.1 An inmate is required to apply to Corrective Services if they seek to have a nominated member of the public included on an approved list of persons permitted to be called by the inmate. The calls have a maximum duration of six minutes and all calls except calls to a legal practitioner are recorded by Corrective Services.

7.2 Police reviewed WM's telephone call logs between 2011 and March 2018. His call logs recorded him making 152 calls. Between 1 October 2018 and 3 April 2020, he attempted to place five calls, with only two of these calls being successfully connected.

7.3 The first of these calls was made on 18 March 2020, to a friend [redacted]. The call duration was 42 seconds. Police contacted [redacted], who confirmed that she had known WM since 2009. She told police that on a number of occasions over the years, WM had made comments that he had "nothing to live for" and other comments that gave her the impression that he was depressed and was possibly contemplating self-harm, although he never specifically made threats to self-harm or suggested a plan to end his life.

7.4 The second call was made on 2 April 2020 at 11.24am to his solicitor, Mr Archbold. Police spoke with Mr Archbold who confirmed that WM had left a message at his practice requesting Mr Archbold organise a representative from the US Consulate visit WM at Lithgow Correctional Centre. No reason was given for this request.

8. **Post Mortem Examination**

8.1 Senior Staff Specialist in Forensic Pathology, Dr du Toit-Prinsloo prepared a post-mortem report dated 12 May 2020.

8.2 Dr du Toit-Prinsloo noted that the post mortem radiology "shows gliotic changes in the right temporal lobe in keeping with prior head injury. There are fractures of the right greater cornu of the hyoid bone and the right superior cornu of the thyroid cartilage in keeping with hanging".

8.3 Dr du Toit-Pinsloo noted that the post mortem external examination showed "features in keeping with hanging as cause of death including a ligature abrasion mark around the neck and a ligature present with the body."

8.4 The toxicological examination detected "no alcohol in the blood and vitreous humour samples. Carbamazepine (used in the treatment of epilepsy), metoprolol (used in the treatment of hypertension) and mirtazapine are present in blood in non-toxic levels. These do not contribute to the cause of death."

8.5 In Dr du Toit-Prinsloo's opinion, the cause of WM's death was in keeping with hanging.

9. **Hanging Points in Cells**

9.1 Detective Cole noted that the ligature appeared to have been fashioned from the bed sheet hemming material. He noted that WM appeared to have used the same bed sheet material previously to erect a clothesline and as a support for a shower curtain.

9.2 Detective Cole noted that both the clothesline and the shower curtain support were easily visible from the front cell door and was of the view that Correctional Officers would have been able to observe them during routine inspections and roll calls prior to WM's death.

9.3 Detective Cole was of the opinion that these structures should have been removed for two reasons. The first reason was that any clothes hung on the makeshift clothesline may have obstructed the view of WM within his cell by Correctional Officers conducting routine inspections through the cell door inspection window. The second reason he raised related to the obvious risk that these structures could be used as a ligature.

9.4 On 22 May 2020, Detective Cole spoke with the then Lithgow Correctional Centre Governor, Ms Slatcher who confirmed that it was a breach of policy for inmates to erect clothes lines or similar makeshift structures within their cells, irrespective of what material was used. Governor Slatcher confirmed that this was difficult to enforce due to continual non-compliance by inmates. Governor Slatcher noted that as soon as one temporary structure was removed, inmates would simply re-erect another.

9.5 Detective Cole was of the opinion that the "failure of Correctional Officers to remove the clothesline and shower curtain support from the deceased's cell is not a major contributing factor to his death. There were a number of other items within the deceased's cell that could have been easily altered, or manipulated by him in order to make a ligature including clothing items and the bed linen used by him to sleep in. By removing all items from the deceased's cell that could possibly be used as a ligature, would in my opinion be unreasonable, especially considering that he was to remain in custody for the remainder of his natural life."

9.6 The former Governor of Lithgow Correctional Centre, Mr Michael Green, confirmed that at the time of WM's death the only policy directly addressing hanging points at the gaol was contained in the policy regulating cell placement and inmate accommodation known as "Custodial Operations Policy and Procedures, COPP s5.2 Inmate Accommodation." The policy states that any inmate showing or deemed to be at risk of self-harm is assessed and housed in an assessment cell. At the time of his death, WM had not exhibited any signs of risk of self-harm sufficient for him to be placed in an assessment cell.

9.7 Governor Green confirmed that all other cells within the Lithgow Correctional Centre have hanging points, such as beds, shelves and sinks. At the time of his death, WM was housed in a segregation cell which had additional hanging points, which included window bars and grilles.

9.8 Corrective Services NSW confirmed that there is a minor works program in place which included the removal of hanging points. In the 2020-2021 financial year, a total of 406 cells had been, or were in the process of being refurbished at Junee, Long Bay and Parklea Correctional Centres.

9.9 On 6 September 2023, Assistant Commissioner Craig Mason provided a statement addressing the current status of the state-wide removal of hanging points within Correctional facilities within NSW. He confirmed that during the 2022-2023 financial year, $2.4 million was spent on cell

refurbishments, including the identification and removal of obvious hanging points.

9.10 Assistant Commissioner Mason confirmed that due to access limitations and materials shortages in the financial year 2022-2023, $6 million was requested from capital funding to be carried forward into the 2023-2024 financial year, in addition to the minor capital works funding. He confirmed that Lithgow Correctional Centre was not currently listed for the cell refurbishment program.

10. **Conclusions**

10.1 The evidence tendered in these proceedings makes it clear that WM's cause of death was in keeping with hanging. It is noted that WM's note referred to "One of them got here first and they probably weren't happy."

10.2 I am satisfied on the available evidence that no other person entered WM's cell between the hours of 7.05pm on 2 April and 8.20am on 3 April 2020. In addition, no other person entered the exercise yard adjacent to WM's cell during the relevant period.

10.3 I am satisfied that WM made no suggestions of self-harm in the days preceding his death and appeared to be accepting of his forthcoming move to Unit 6.1.

10.4 I am satisfied that no suicide note was located by police and that WM did not make any telephone call to a third party indicating such an intent. I am satisfied that the note located in his personal possessions was not consistent with a suicidal ideation.

10.5 It would appear that WM received adequate psychiatric support during his period of incarceration.

10.6 I am satisfied that the manner of WM's death was not suspicious and was consistent with a self-inflicted injury and was inflicted with an intention of ending his life.

10.7 I am satisfied that at the time of his death, WM was lawfully in custody.

10.8 The availability of hanging points within correctional centres remains an issue of concern. It would appear that this issue is being addressed by Corrective Services, NSW, albeit slowly.

10.9 I would like to acknowledge and thank Mr Durand Welsh, Coronial Advocate for his assistance in the preparation and presentation of the evidence in this case. I would also like to acknowledge and thank the Officer in Charge of this case, Detective Senior Constable Andrew Cole for his investigation and collation of the brief of evidence.

11. **Findings**

The findings I make under section81(1) of the Act are:

Identity

The person who died was WM

Date of Death

WM died on at sometime between 2-3 April 2020

Place of Death

WM died at the Lithgow Correctional Centre, 596 Great Western Highway, Marrangaroo

Cause of Death

The cause of WM's death was in keeping with Hanging

Manner of Death

WM died from self inflicted injuries with the intention of ending his life

I now close this inquest.

Magistrate Joan Baptie
Deputy State Coroner
6 March 2024
Coroners Court of New South Wales