CORONERS COURT
NEW SOUTH WALES

Inquest:	Inquest into the death of **AB**
Hearing dates:	16 June 2015
Date of findings:	16 June 2015
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death- death in custody-suicide.
File number:	13/265085
Representation:	Ms D Williamson Police Advocate Assisting. Mr. Hudson representing AB's family Mr Griffiths representing Corrective Services Mr Woods representing Justice Health
Findings:	Identity of deceased: The deceased person was AB Date of death: He died on 30 August 2013 Place of death: He died at Goulburn Correctional Facility Manner of death: Suicide Cause of death: Hanging

NOTE: PURSUANT TO S 75 (5) OF THE CORONERS ACT 2009 I PERMIT A PUBLICATION OF THE REPORT OF THIS MATTER HOWEVER EVIDENCE IDENTIFYING THE DECEASED OR ANY MEMBERS OF HIS FAMILY SHALL NOT BE PUBLISHED IN ANY REPORT AND THE DECEASED SHALL BE REFERRED TO BY THE PSEUDONYM AB

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

1. This inquest concerns the sad death of AB. He was only 34 years of age when he took his own life while he was an inmate at Goulburn Correctional Centre.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

   The Act also requires a Coroner to conduct an inquest where the death appears to have occurred "*while in lawful custody".* (s.23, s.27)

> *"The purposes of a s. 23 Inquest are to fully examine the circumstances of any death…, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."*[1]

[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

3. AB was born on 23 April 1979. He is a much loved son and brother.

4. He had a limited criminal history relating to supply and possession of drugs.

5. On 28 May 2013 he entered the custody of Corrective Services NSW for the first time. He was on remand for supply of a commercial quantity of Methamphetamine (7.3kg). The next mention date was 08 October 2013.

6. On 29 May 2013 in a screening interview he informed Corrective Services NSW that he was affiliated with the Hells Angels Outlaw Motorcycle Group. Accordingly, he was not placed in the same wing as rival motorcycle groups.

7. On 31 May 2013 Justice Health completed a 'Reception Screening Tool' document and concluded that there were *'nil medical issues identified'*. No Risk Intervention Team (RIT) plan or alerts were identified as being required for his medical management in custody.

8. On 04 June 2013 a CSNSW 'Initial Classification' was completed. During this process AB advised that his father had committed suicide 12 years earlier and that he'd been seeing a counsellor about the incident. He was not identified as a risk of self-harm and was secured in remand at Parklea Correctional Centre.

9. On 06 June 2013 AB advised that other inmates at Parklea Correctional Centre believed he was a Police Officer and had threatened his life. As a result he was provided with Special Management Area Placement (SMAP) at Parklea. He was subsequently relocated to Goulburn Correctional Centre on 30 July 2013.

10. On 23 August 2013 he appeared in Court on a bail application. His mother provided an affidavit to the Court which set out that she was concerned about the deterioration of his wellbeing in Goulburn Correctional Centre[2]. She has informed this Inquest that she thought her concerns contained in that affidavit would be passed on to Correctional Services. Despite this misunderstanding, having read the affidavit, I am of the view that Correctional Services would not have necessarily formed the view that AB was at risk of self harm.

11. At 11:41am on 24 August 2013 AB made an Offender Telephone System (OTS) telephone call. During the call he indicated he had nothing left and that he was struggling with the fact he may be sentenced to life. He said if he got life he would last a week and there was no way he was doing life. At 10:14am on 28 August

[2] Ex 5

2013 he made a further OTS telephone call to the same friend. He left a voice message saying that he loved the recipient of the call and said goodbye.

12. At 10:49am on 28 August 2013 AB made an OTS telephone call to a different friend. During the call he indicated that he was bail refused at Court and they told him he was getting life or 25 years which had shattered and devastated him. When asked about seeing his mother on the weekend he said it was hard to say goodbye.

13. At 10:06am on 29 August 2013 AB made an OTS telephone call to another friend. During the conversation he indicated he was doing it tough and really struggling. He said he wanted to go home badly.

14. On 29 August 2013 he was secured in Cell 44 in Unit 2 with inmate Christopher Hibbard. Mr Hibbard described AB as seeming down and out, depressed and miserable. He said AB had spoken to him several days before his death about a family member taking their life and that he felt he should do the same.

15. At 6:40am on 30 August 2013 Correctional Officers unlocked the door to Cell 44 in Unit 2 to take Mr Hibbard for transfer for Court. Whilst leaving the cell Mr Hibbard saw that AB had a blanket over his face but said that he was awake at the time. AB wished Mr Hibbard good luck. There were no indications for concerns of welfare of AB at this time.

16. At 8:30am on 30 August 2013 during the inmate 'let go' procedure in Unit 2 AB was located suspended by his neck from the window at the rear of Cell 44. He was cut down and the ligature removed from his neck. CPR was commenced without success. Life was pronounced extinct at 9:10am.

17. A forensic crime scene examination was conducted. A handwritten 'suicide note' addressed to his mother was located.

18. A post mortem examination was conducted by Dr Rebecca Irvine and I accept her opinion that the cause of death was a result of hanging.

19. Whilst in CSNSW custody AB was able to contact twelve nominated persons via telephone and he did so on a daily basis. He also had 38 physical visits from friends and associates whilst in custody.

20. AB planned his death. This is supported by the suicide letter written to his mother telling her that he was sorry for taking his own life. It appears he deliberately suspended himself from the window in Cell 44 in desperation of the prospect of a lengthy custodial sentence. There is no evidence available to suggest that CSNSW or Justice Health were aware that he was contemplating these actions.

21. I accept the Officer-in-Charge's opinion that AB was screened sufficiently and that his cell placement was appropriate. All protocols were followed by Corrective

Services with regard to deaths in custody. The Crime Scene was managed by Corrective Services staff in an efficient and competent manner.

22. In relation to Justice Health, it appears he received satisfactory treatment

23. AB's mother says that she did not realise she could speak to someone at Corrective Services about her concerns of AB's welfare. Corrective Services and Justice Health have provided copies of the material and information that is available for support of inmates and their families. A copy of this material is Exhibit 2 and Exhibit 3. This material shows that there were a number of avenues that she could have pursued. While AB's mother accepts this material may well have been available she says that she was never made aware of it. Corrective Services would do well to be aware of her experience and ensure all possible steps are made to ensure the material is appropriately displayed and available.

Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased
The deceased person was AB

Date of death
He died on 30 August 2013

Place of death
He died at Goulburn Correctional Centre

Cause of death
The death was caused by hanging

Manner of death

Suicide

I close this inquest.

C Forbes

NSW Deputy State Coroner

Glebe

Date: 16 June 2015