STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Wotherspoon
Hearing dates:	30, 31 January, 1, 2, and 3 February 2017 at Newcastle
Date of findings:	31 August 2017
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – death in custody; mental health services and security in correctional centres; internal autopsies and external examinations for deaths in custody
File number:	2013/114526
Representation:	Counsel Assisting the Coroner, Mr Peter Aitken, instructed by Tracey Howe, Crown Solicitor's Office Counsel for Mr David Wotherspoon Senior and family, Mr James Jeffrey, Aboriginal Legal Service Counsel for Ms Corina Mason, Mr Phillip Massey, instructed by Ms Donna Smith, O'Brien Winter Partners Counsel for Corrective Services NSW, Ms Gillian Mahoney, instructed by Ms Susan Binning, Department of Justice Counsel for Justice Health, Forensic Mental Health Network and NSW Health Pathology, Mr Steven Wood, instructed by Mr Les Sara, Hicksons Lawyers Counsel for Dr Christopher Bench, Mr Simeon Beckett, instructed by Ms Kate Donnelly, Meridian Lawyers

Findings:	**The identity of the deceased** The deceased person was David William Wotherspoon. **Date of death** Mr Wotherspoon died on 14 April 2013. **Place of death** Mr Wotherspoon died at John Hunter Hospital, Newcastle. **Cause of death** The medical cause of his death was hypoxic encephalopathy caused by neck compression due to hanging. **Manner of death** David Wotherspoon died from injuries sustained nine days before his death when he deliberately tied a ligature around his neck and attached the other end to the door locking mechanism in his prison cell and suspended his weight from it with the intention of ending his life.

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The Coroners Act in s. 81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of David William Wotherspoon

Introduction

1. David Wotherspoon died at the John Hunter Hospital on 14 April 2013, nine days after he had been transferred there from the Cessnock Correctional Centre where he had been found in his cell with a ligature around his neck on 5 April 2013. He was 31 years of age.

The inquest

2. Section 81 of the *Coroners Act 2009* requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

    - the identity of the deceased;
    - the date and place of death; and
    - the manner and cause of the death.

3. Pursuant to the combined operation of ss. 21(1)(a), 22(2) and 23(d)(ii) of the Act, a senior coroner has exclusive jurisdiction to hold an inquest concerning the death of a person if it appears that the person has died while an inmate of a correctional centre.

4. Under s. 82 of the Act a coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

5. In this case, there is no doubt that Mr Wotherspoon died at the John Hunter Hospital on 14 April 2013. The focus of this inquest has been upon whether better management of the risks arising from his mental health condition while an inmate of Cessnock Correctional Centre could have avoided the death, the medical cause of his death and whether any recommendations should be made under s. 82.

Social history

6. David Wotherspoon was born on 13 December 1981 in Newcastle. He was aged 31 when he passed away. David was an Aboriginal man. He was the much loved son of David Wotherspoon Senior and Sharon Wotherspoon, and a brother to six sisters and one brother.

7. At the time of his death, David was the de facto partner of Corina Mason and stepfather to Corina's three children.

8. Mr Wotherspoon Senior described David as a "bit of a wild child" when he was growing up. David completed his schooling in year 6. He had a history

of substance abuse, having started using methyl amphetamines when he was about 14 years old. When David was about 18, he moved to Tasmania with some friends and family members and lost contact with his parents. After some time, however, Mr Wotherspoon Senior bought David a ticket to bring him back home.

9. David had developed serious mental health problems that may have been exacerbated by drug use. On his return to Newcastle, he lived with his parents for several years and initially made a significant recovery, with his parents' help.

10. However, he began to use drugs again and during a psychotic episode, slashed his throat with a pen knife and nearly died. After David was released from hospital, he spent a lengthy period as an inpatient of the James Fletcher Mental and Rehabilitation Centre and then the Morisset Hospital, a specialist psychiatric hospital.

11. When David was discharged from Morisset Hospital, he was in good health and started a course at TAFE in Aboriginal art, numeracy and literacy. The mental health team at the hospital assisted David in finding a 2 bedroom unit in Merewether in which to live.

12. David and Corina met in about late 2006 while David was at Morisset Hospital and Corina was visiting a friend. Corina moved into David's Merewether apartment in about 2010 and they lived together until David's incarceration in 2012.

Criminal justice history

13. Between 1995 and 1999, David committed a number of offences as a juvenile, which are not relevant for present purposes.

14. On 14 March 2011, David was charged in relation to an incident involving the wounding of a person. He was taken into custody at the Metropolitan Remand and Reception Centre, Silverwater ("MRRC") that day. David was subsequently transferred to the South Coast Correctional Centre and Cessnock Correctional Centre ("Cessnock") before being released on bail on 29 November 2011.

15. On 25 April 2012, David was charged with aggravated break and enter. He was arrested and taken back into custody at the MRRC.

16. On 31 August 2012, David was sentenced for the offences of recklessly wound any person and aggravated break and enter (the 2011 and 2012 charges respectively). His aggregate sentence was 3 years and 8 months expiring on 9 April 2015, with a non-parole period of 2 years and 6 months concluding on 9 February 2014.

Medical history

17. David was diagnosed with schizophrenia in about 2002. As set out above, David was an inpatient at the Morisset Hospital for an extended time and other mental health facilities including the Mater Mental Health Hospital.

18. David was taken into custody on 14 March 2011. Soon afterwards, David slashed his throat in a suicide attempt on 16 April 2011 which he attributed to withdrawing from methamphetamine use.

19. When David was taken back into custody on 25 April 2012, his intake assessment identified a range of health concerns including illicit substance abuse, hepatitis C and serious mental illness with a history of self-harm and suicide attempts. He was treated with fortnightly antipsychotic injections to treat schizophrenia as well as being prescribed diazepam.

Events preceding the death

Return to custody

20. David was arrested and returned to custody at the MRRC on 29 April 2012 when he was charged with aggravated break and enter. After subsequent transfers to Cessnock, Parklea and Bathurst Correctional Centres, he was transferred back to Cessnock on 11 August 2012 and then sentenced on 31 August 2012.

21. At Cessnock, David was initially housed with the prison's general population. He reported on reception there that he was prescribed fortnightly antipsychotic depot medication and diazepam (Valium) which he had recently stopped taking.

22. The existence of psychosis was queried on a psychiatric review on 10 May 2012, but David was maintained on antipsychotic medication Ripseridone 50mg injections. A subsequent psychiatric review in September 2012 documented that David was stable and that there were nil signs of psychosis.

23. On 17 October 2012 David was reviewed by Dr Bench, psychiatrist, who continued the Risperidone injections.

24. On 27 November 2012, David was reviewed by a mental health nurse who noted that he was irritable and refused his regular depot injection, claiming that it had been increased in dose (to 50mg) when it had not in fact been.

25. On 5 December 2012 David was reviewed by Dr Bench and denied any mental illness and said in effect that all past signs and symptoms were secondary to substance abuse. No recent behavioural concerns were noted.

26. "*Ongoing compliance*" issues were noted on 9 December 2012.

27. On 18 January 2013 Dr Bench and Nurse Kibble reviewed David and noted that he was refusing medication, denied schizophrenia but was assessed as having schizophrenia but not showing any signs of psychosis.

28. On 8 March 2013, when David was reviewed by a drug and alcohol counselor he disclosed that he had been using buprenorphine, an opiate.

29. On 14 March 2013, Nurse Kibble again reviewed David. She observed various concerning signs including psychomotor agitation. He alleged that Corrective Services staff were poisoning his food and he wouldn't sleep for fear of being murdered. He said he was armed with a shiv to protect himself and was ambivalent about taking medication, saying he was not sick. He surrendered the shiv, a sharpened screwdriver, to Senior Assistant Superintendent ("SAS") MacGregor.

30. He was admitted to Cessnock's then Mental Health Unit ("MHU") on Nurse Kibble's recommendation and agreed to take medication prescribed by Dr Bench including diazepam at 10mg 4th hourly to a maximum of 30mg daily and a reduced dose of risperidone.

31. The Mental Health Unit at Cessnock was a separate part of the jail comprising 8 to 12 cells which in the first part of 2013 housed a number of inmates with diagnosed mental health issues. It was adjacent to the Justice Health Clinic.

32. David asked to be referred to the Mental Health Screening Unit ("MHSU") at Silverwater where he had been treated in the past. This is a purpose built mental health facility designed to enable multidisciplinary assessment and treatment. It provided these services to prisoners from across the state. There was often a waiting list for admission to the unit.

33. On 15 March 2013, Dr Bench reviewed David and noted "*decompensation of mental illness*". David alleged his cell was being poisoned via the toilet and that he was not eating and drinking for fear of being poisoned. He had reportedly lost 7kg whilst off his medication. He reported Buprenorphine abuse. David reluctantly accepted the new medication of diazepam and risperidone 4mg but adamantly refused to go back onto the risperidone injections. He denied suicidal ideations or a desire to harm others.

34. Dr Bench decided David should be referred to the MHSU at Silverwater. In the meantime, Dr Bench recommended that David remain in the MHU at Cessnock under a Risk Intervention Team ("RIT") Protocol. Dr Bench expected that the form seeking a bed for David in the MHSU would be completed and forwarded to Silverwater on 15 March 2013.

35. The transfer was urgent because in Dr Bench's view the Cessnock MHU was not a suitable facility for treating acutely psychotic prisoners such as was David Wotherspoon.

36. However, for reasons which were not adequately explained, the form was not completed until 21 March 2013. Nurse Kibble indicated that she cannot now recall if the referral was to be given priority but she absent from work from 16-19 March 2013 inclusive and attended to this administrative task two days after she returned to work.

37. David could not be compelled to take his medication as he was not on a community treatment order under the *Mental Health Act 1990.* Dr Bench considered it was not necessary to have David scheduled under that Act because he could be monitored in the MHU while he waited for admission to the MHSU.

38. Progress notes record David as "*extremely agitated*" and refusing to take medication at 10.30pm on 15 March, but David accepted his prescribed medication on 16, 17 and 19 March.

39. He was reviewed again by Dr Bench on 20 March and found to be partly medication-compliant with risperidone and psychotic with the same delusions as previously described.

40. On 21 March various sharpened items were found in his cell and removed.

41. On 22 March David returned a positive test to buprenorphine and had some privileges withdrawn as a consequence.

42. On 24 March David missed a visit from his partner Ms Mason and sister Simone Wotherspoon, who had arrived at the correctional centre outside visiting hours. David became upset and self-harmed with a glass that he smashed in his cell. An incident report was prepared by Correctional Officer ("CO") Harcourt, who was on duty in the Mental Health Unit at the time. CO Harcourt noted that he had observed David cover the camera in his cell and went to check on his welfare, which is when the self-harm incident happened.

43. The practice of inmates covering cameras in their cells appears to have been known amongst correctional officers. The RIT review by Nurse Kibble and SAS Hamilton concluded that David was threatening to cut his own throat and threatening to kill staff.

44. SAS MacGregor ordered all cells in the MHU to be searched for sharp objects and a mandatory notification to the RIT was made.

45. David was placed in a cell with constant camera monitoring on 24 March.

46. On 26 and 28 March, Nurse Kibble reviewed David, who reported the same delusions. He would not rule out further self-harm. An RIT assessment was carried out on 28 March by Nurse Kibble and SAS MacGregor and a Dianna Eberzy, Corrective Services psychologist.

47. David was recorded as "*distressed, confused, angry, cannot say he will not hurt himself again*" and was to have ongoing camera monitoring. A further RIT review was scheduled for 2 April. Nurse Kibble made a progress note about the review, noting David's belief that he was being poisoned.

48. Psychologist Ms Ebzery recorded on 28 March 2013 that

> *Mr Wotherspoon was co-operative and engaging. He appeared remorseful for his actions and was able to identify more appropriate methods of coping and resolving internal conflict. Although he continues to deny having any thoughts or plans for self-harm, his behaviour exhibits high impulsivity and poor consequential thinking. He appears to have greater insight into his mental health issues, but is still quite paranoid about discussing symptoms or particulars with anyone other than the mental health nurse. Mr Wotherspoon continues to be of the belief that his clozapine injections are attempts to poison him, but has been compliant with other anti-psychotic medication.*

49. On 30 March David remained paranoid and is recorded as refusing medication the night of the 29 March. No record appears to exist of any administration of diazepam after 29 March.

50. David saw his de facto partner Ms Mason and his sister Simone on 31 March 2013 and talked about how the guards were trying to kill him. Ms Mason told him that she thought he was being paranoid

51. Nurse Kibble reviewed David at 12.15pm that day and recorded that he "*remains very preoccupied with officers poisoning him*" (he could "*see needle marks on his fruit*") and was very anxious to go to the MHSU.

52. On 1 April, Nurse Kreft saw David, noting that he was eating and there was nil talk of food tampering. She also saw him on the morning of 2 April when he seemed suspicious of his food and appeared calm but wanting to go to the MHSU.

53. A further RIT review was conducted on 2 April with Correctional Officers Harrower and Belcher and Nurse Kreft present, at which David again said that he believed he was being poisoned but he is recorded as not at risk self-harm, and to have "*CCTV medical 1 out*". He was moved to cell 8 and permitted to have his cell light off at night and access to cigarettes and matches. A RIT review was scheduled for 5 April.

54. There is no progress note on the file for 4 April. On 4 April David's acceptance to the MHSU (dated 3 April) apparently came through on the fax, dated at about 10.15am. However, the Metropolitan Transport truck had already departed when the approval was received and processed. The next truck was not due until 6 April.

55. A Drug and Alcohol progress note from 5 April 2013 records a request for "OST" (Opioid Substitution Treatment program) being reissued, stating "*reports he is currently injecting bup daily in custody*".

The events of 5 April

56. On 5 April Correctional Officers Harrower and Slingsby were on duty at F Wing (the MHU) from 8:00am. Nurse Kibble saw David briefly in the morning and reported that he did not give her any immediate concerns.

57. A RIT review at 2.15pm conducted by Nicole Buchanan, Corrective Services psychologist, CO Harrower and SAS MacGregor noted that he was still delusional. David was informed that his transfer to the MHSU had been approved and he is recorded as seeming happy, being scheduled to leave the following day. Ms Buchanan later told investigators that David appeared to show some insight in that he acknowledged that his belief that he was being poisoned was "*not right*" She said that nothing he said or did gave her any concern that he might self-harm.

58. After the RIT assessment, David was taken to the phone located in the Mental Health Unit common room to make a phone call to Ms Mason. She later told investigators that she recalled speaking to him about 2.27pm and David saying words to the effect that "*I'm ready to go. I'm ready to do it now*". Ms Mason told investigators later that she asked him what he meant and he said "*nothing, see you later*".

59. The recording of the phone call that was made as standard procedure did not bear out that portion of the conversation as recalled by Ms Mason. On the contrary, David sounded happy and there is no indication of imminent self-harm. It is likely that she has mistaken David telling her he was ready to go to the MHSU as an indication of an intent to self-harm.

60. David was returned to his cell by SAS MacGregor at about 2.45pm. Before that occurred another officer gave Mr Wotherspoon some tobacco and cigarette papers at his request and spoke to David as he rolled a cigarette. That officer said David seemed calm and compliant.

61. At about 3.06pm, David began trying to cover the lens on the camera in his cell with what appears to be wet toilet paper. Those attempts were renewed at about 3.14pm, this time with paper covering the central portion of the lens, which had the result of concealing/preventing a view of the inside of the closed door to his cell.

62. At about the same time an adjoining cellmate, Mr Ingram, was recorded as 'knocking up' on the cell alarm. The reason recorded in the Monitor Room journal was for a phone call. A further 'knock up' by Mr Ingram at 3.29PM was recorded as wanting a shower.

63. At around 3.25pm CO Harrower rang CO Jenny Archer, who was on duty in the central Monitoring Room, about an allocation list. The central Monitoring Room had banks of television screens showing camera feeds from various locations around the jail, including the safe cells in F wing (MHU). The images relayed from each of the MHU cell cameras were all contained on the one big screen as 64 separate images.

64. CO Archer told the investigators that she did not notice the paper covering the lens in David's cell until just before David was found by the officers delivering meals. At the inquest she sought to assert that she had in fact seen David attempting to cover the camera in his cell but had not reported it to the officer in the wing because the attempts were unsuccessful. For the reasons set out in counsel assisting's submissions I conclude that this evidence is unreliable.

65. An officer stationed in the Monitor Room at that time had to monitor the 64 sections of monitor screen, take phone calls from all over the complex and answer cell call alarms.

66. When an inmate is on 24 hour CCTV monitoring, responsibility for the monitoring falls to the monitoring officer whenever the officers in the MHU are away from their work stations.

67. At around the time at which David is shown on the CCTV as starting to put paper on the camera lens, Senior Correctional Officer ("SCO") Harrower and CO Slingsby began meal distribution to the F wing inmates.

68. While occupied in this task they were not able to monitor the cameras in the F Wing cells. Video of David's cell subsequently retrieved showed him moving around just before 3.20pm, then officers appeared at the door of his cell at 3.35pm. It was only when SCO Harrower went to deliver David his meal that he was found, apparently unconscious.

69. Looking through the door window, CO Slingsby could see David seated on the floor by the door. He called out and got no reply and then saw David's head tilted to one side and his tongue hanging out of his mouth. He asked SCO Harrower to open the cell door and as he did so David slid down onto the floor.

70. CO Slingsby ran to the officers' station to get a cut down knife. A few seconds later, when he got back to David's cell, he saw SCO Harrower attempting to free something from around David's neck.

71. SCO Harrower described finding David "*slumped against the grill on the inside of the cell door*" with a cord that had been put over the bolt latch on the door, thus creating resistance when he tried to open the bolt.

72. SCO Harrower found the other end of the cord "*wrapped round his* (David's) *throat*" and removed it by placing his finger under it and pulling the noose free, which he described as a "*truckies slip knot*".

73. SCO Harrower began chest compressions and called for CO Slingsby to radio a medical emergency

74. CPR was continued with a face mask. Dr Bench arrived with a defibrillator, followed by nursing staff with oxygen. CPR was continued until a pulse was detected. A Justice Health emergency response form records CPR at 3.40pm and ambulance arriving at 4.11pm. A heart rate appears to have been monitored/detected from at least 3.50pm. David's pupils were described at that time as "*fixed/large*".

75. Ambulance records show that on the arrival of paramedics, David had a Glascow coma score of 3, a pulse of 60 beats per minute, and normal and reactive pupils. Multiple doses of morphine were administered.

Events after the fatal incident

Hospital treatment

76. At 4.45pm David was taken to John Hunter Hospital by ambulance where cerebral hypoxia was diagnosed by an EEG and MRI. By the early hours of 6 April, David had been diagnosed with irreversible brain damage.

77. He remained intubated, sedated and hydrated in the ICU but over the following 10 days he did not regain consciousness.

78. Hospital records showed the following drugs as having been therapeutically administered, midazolam, morphine and adrenaline.

79. Ante mortem blood samples taken on David's admission on 5 April 2013 at a time recorded in the toxicology certificate as 6.00pm showed the presence of Nordiazepam 0.01mg/L; Midazolam 0.10mg/L; morphine (free) 0.05mg/L; Morphine-3-glucuronide 0.22mg/L; Morphine-6-glucuronide 0.03mg/L.

80. On 12 April the family made a decision after medical advice to withdraw assisted ventilation. David passed away at 11.50am on 14 April.

Family notification

81. Ms Mason told investigators that at some point in the afternoon of 5 April she received a call from David's sister Simone, who told her that her boyfriend had heard over a police scanner that something had happened to David.

82. Ms Mason rang Cessnock and spoke to officer Guy Sim, the Manager of Security, who told her that David had been taken to hospital. A report noting that "Next of kin informed" is time stamped 4.49pm.

Autopsy order

83. In accordance with established procedures, the duty pathologist at the Department of Forensic Medicine in Newcastle sought and obtained an autopsy order in relation to David's body. That process followed the following steps.

84. A copy of the initial police report of the death to the coroner, the form P79A, and a summary of the circumstances of death and the treatment provide by the hospital, the form A, were provided to the duty pathologist at the Newcastle Department of Forensic Medicine, Professor Timothy Lyons.

85. After reviewing the available material, Professor Lyons forwarded to the office of the Newcastle Deputy State Coroner a from headed "Request for coronial direction" in which he set out some details of the circumstances of David's death and made the following recommendation:

> *Given the time difference* (between the fatal incident and death) *and the known cause of death I cannot see the benefit in an autopsy as the cause is already known. I suggest an ext + review of records.*

86. He also noted, "*We will try and obtain ante mortem bloods."*

87. Professor Lyon's recommendation was accepted and an autopsy order consistent with it was made by the Newcastle Deputy State Coroner.

Autopsy evidence

88. On 15 April an autopsy in accordance with the coroner's order was undertaken by an experienced forensic pathologist, Dr Allan Cala.

89. He examined the external surfaces of David's body and reviewed the medical records from John Hunter Hospital. He noted that there was a faint ligature mark on the right side of the neck and numerous scars on both forearms consistent with previous attempts at self-harm. There were no other injuries and no external signs of disease.

90. Based on the hospital records which included scans of David's head and upper body, analysis of his blood when he was admitted to hospital and progress notes detailing the observations and conclusions of the specialists who treated him, Dr Cala concluded that the cause of David's death was hypoxic encephalopathy, due to neck compression, due to hanging. He issued an autopsy report detailing those findings and conclusions.

Family's pathologist

91. The family retained a former NSW Health Pathology forensic pathologist to review some of the material. Professor Johan Duflou prepared two reports relating to the question of David's cause of death.

92. In his first report Professor Duflou agreed that if the circumstances as outlined in the P79A were correct, the mark on David's neck could reasonably be attributed to a ligature and hanging. He conceded that if this were the case, the cause of death as found by Dr Cala was reasonable.

93. However, Professor Duflou queried whether the morphine and nordiazepam found in ante mortem blood taken on admission to the John Hunter Hospital may have been the result of illicit use of heroin and diazepam. He suggested such drugs could in combination cause respiratory arrest.

94. In a second report prepared after Professor Duflou had reviewed the medical records from the John Hunter Hospital he repeated his concerns about the drugs found in David's ante mortem blood sample.

95. In both reports Professor Duflou also questioned the appropriateness of Dr Lyons not recommending an internal autopsy in view of David dying as a result of an in custody event. I shall return to that issue below.

Independent toxicology

96. An independent clinical toxicologist, Professor Alison Jones was briefed by those assisting me to respond to the concerns raised by Professor Duflou. She advised that the diazepam administered to David in prison is likely to have resulted in the presence of nordiazepam found in his ante mortem blood sample. The level of the drug was at a sub therapeutic level and unlikely to have contributed to his death.

97. Further analysis of the blood sample showed an absence of the metabolite 6-Monoacetylmorphine excluding heroin as the source of the morphine and confirming it was a result of the morphine administered by the ambulance officers who responded to the incident.

98. It is regrettable that Professor Duflou would raise these baseless concerns when their only effect was to unnecessarily distress David's family.

Death investigations

99. Because of the serious nature of the injury suffered by David it was reported to police soon after he left the correctional centre in the ambulance.

100. Two general duties officers attended and spoke to the correctional officer who had found David hanging and the security manager.

101. They inspected the cell and instructed that it be secured.

102. Crime scene officers attended, photographs were taken and relevant exhibits were seized.

103. When David died on 14 April 2013, an identification statement was obtained from his mother and a P79A was prepared to report the death to the coroner. Responsibility for the investigation was delegated to Detective Inspector Garry James of the Corrective Services Investigations Unit.

104. Inspector James interviewed all relevant witnesses and obtained all relevant records. He undertook a comprehensive investigation and produced a detailed report.

105. He identified a number of factors that may have contributed to opportunities to prevent the death being missed. These included: inadequate staffing of the monitoring room; the availability of a ligature to an at risk prisoner; and a hanging point in the cell of an at risk prisoner.

106. An internal investigation was also undertaken by Acting Assistant Superintendent Graham Kemp of the Corrective Services Investigations Branch and referred to the Corrective Services Deaths in Custody Management Committee.

107. Both investigation reports were tendered into evidence at the inquest.

Review of psychiatric care

108. The court was assisted by a review of the psychiatric care provided to Mr Wotherspoon while he was in Cessnock Correctional Centre undertaken by Associate Professor Michael Robertson, a consultant psychiatrist.

109. Associate Professor Robertson observed that it was likely that Mr Wotherspoon suffered from schizophrenia complicated by poly substance abuse including illicit substances obtained while he was in prison.

110. He considered it likely that David's psychiatric problems were also exacerbated by intermittent or non-adherence with his antipsychotic medication.

111. He concluded:

> *Having reviewed the brief of evidence, I am satisfied that the best standard of care was provide in the circumstances, but that the deceased's transfer to a more specialized health care setting, specifically the Mental Health Screening Unit, would have enabled more assertive management and precluded the exacerbating effects of illicit drug use.*

112. He considered it likely that David was suffering from paranoid psychosis when he took the action that resulted in his death.

113. In Associate Professor Robertson's opinion, more assertive attempts to gain medication compliance were warranted, with resort of the Mental Health Act

scheduling regime if necessary. Indeed, he considered the Mental Health Act should have been used to ensure David was consistently medicated when it became clear he was psychotic and resisting treatment in early 2013.

114. He also queried why David was not moved to the MHSU more promptly where he is more likely to have received regular medication and less likely to have had access to illicit drugs. In Associate Professor Robertson's opinion that was the appropriate setting in which to compel medication compliance.

115. Associate Professor Robertson suggested clinicians providing care in a correctional setting would benefit from clearer guidelines as to the utilization of the Mental Health Act in a custodial setting.

Analysis regarding issues of concern

Particulars of death

116. On 5 April 2013, correctional officers delivering meals to inmates at the Cessnock Correctional Centre found David Wotherspoon in a locked cell unconscious with a ligature around his neck. He was given appropriate emergency first aid and life sustaining measures and transferred to a tertiary hospital where despite the best care he died when life support was removed nine days later.

117. Investigations in the hospital established that David had suffered irreversible hypoxic brain injury.

118. Investigations in the prison established that in the 25 - 30 minutes before he was found, David, who had made previous attempts on his life, had made repeated attempts to obscure the view of the surveillance camera in his cell; no other person had entered the cell in the relevant period; and the ligature found around David's neck was a draw string from his pants.

119. An external examination of his body and a review of the scans taken in the hospital enabled the forensic pathologist who undertook the autopsy on David's body to exclude any trauma related injury as contributing to the death.

120. Toxicological analysis of blood taken when he was admitted to hospital eliminated illicit or prescribed drugs as possible contributors to the death.

Conclusion

121. The autopsy report confirmed the hospital diagnosis of hypoxic encephalopathy as a result of neck compression due to hanging as the cause of death.

122. There is no doubt that David did not appear suicidal when he was locked in his cell less than an hour before he took the actions which led to his death. This caused me to consider whether he was at the time so psychotic that he

didn't understand what he was doing. He appeared to be acting rationally when he asked for and was given the makings of a cigarette just before being locked in and his persistence in masking the observation camera does not suggest a loss of comprehension. I conclude that David must have undergone a sudden mood change that led to him deciding to take his own life.

123. Accordingly, the manner, cause, date and place of David's death are readily apparent. The inquest focused on a number of aspects of his care and management that may have contributed to his death occurring or which could be reformed to improve the quality of care provided to correctional inmates. These are my conclusions in relation to those issues.

Adequacy of mental health care

124. As outlined above, the independent psychiatrists who reviewed the mental health care given to David in the months before his death were generally of the view that it was adequate and appropriate.

125. Dr Bench a psychiatrist who provided mental health care to prisoners at Cessnock as a Visiting Medical Officer raised concerns about the time prisoners in the MHU were kept locked in their cells and the requirement that assessment and therapy was on occasions necessarily only able to be undertaken while the therapist stood in a corridor and the prisoner/patient remained locked in his cell. He alluded to prisoners being locked in their cells for up to 23 hours per day and having very limited access to natural light and fresh air.

Conclusion

126. The inquest did not undertake a review of the provision of mental health care to prisoners generally. I will therefore refrain from making general comments about the quality of that care. However, it is notable that two of the practitioners who sought to provide care to David while he was in the MHU withdrew from their respective roles as a result, it seems, of their dissatisfaction with the circumstances in which care was expected to be provided. While the independent experts who reviewed the care provided to David were not critical of it generally, there were obvious problems with aspects of it that are dealt with below.

Compulsory medication

127. One aspect of his care which was questioned was why David was not compelled to take the antipsychotic medication that he obviously needed but which he inconsistently accepted.

128. Assuming that a medical practitioner could have concluded that David was a danger to himself or others, in order for him to be compelled to take the necessary medication he would either have had to have been made the

subject of a Community Treatment Order by the Mental Health Review Tribunal or to have been made the subject of a Forensic Community Treatment Order. In both cases he would have had to have been transferred to a declared mental health facility as the mental health unit at the Cessnock Correctional Centre did not meet the necessary criteria. Those orders can only be made if there is no less restrictive care that would address the prisoner's mental health care needs.

129. In this case it was clear that David was keen to go to an appropriate declared mental health facility – the MHSU at Silverwater. Accordingly, there was no basis to seek to compel him to attend the facility for treatment. If he had been transferred there and he had continued to refuse medication, the steps necessary to administer it compulsorily could have been taken.

Conclusion

130. There was no need or authority to resort to the provisions of the Mental Health Act which enable compulsory treatment until David had been transferred to a declared mental health facility, an arrangement he would have voluntarily agreed to. The problematic delay from a treatment perspective was the failure to decide to transfer him to the MHSU until 15 March, by which time he was he was in crisis. The evidence and expert opinion indicates David's mental health deteriorated without sufficiently prompt and active intervention.

Transfer to the MHSU

131. When it was eventually decided on 15 March to transfer David to the MHSU at Silverwater, for reasons that were not adequately explained but seem to be attributable to an administrative error, there was further unnecessary delay in giving effect to that decision.

Conclusion

132. The failure to transfer David to the Silverwater MHSU in the three weeks from when his treating psychiatrist ordered that to occur until the fatal incident was a significant ommission by those responsible within Justice Health.

Adequacy of accommodation in the MHU

133. The major flaw in the cell in which David was housed was that it contained a hanging point. I accept that the hanging point was obscure and difficult to detect despite the cells being inspected with a view to identifying such defects when they were converted for use by at risk prisoners.

134. I accept that the presence of a hanging point in the cell was due to a human oversight rather than a deliberate refusal to make the cells safe. It has now been rectified.

135. A second observation camera has now also been added to the cells used to house at risk prisoners which should make them safer if the monitoring issue described below is addressed.

Conclusion

136. The presence of a hanging point in the cell in which David was housed and the inadequacy of the monitoring equipment were hidden defects that have since been addressed.

The ligature

137. Various excuses were made as to why David was allowed to have ligatures in his cell. It was variously suggested that he was transferred to the MHU because he was a risk to others, rather than himself and that the on-going RIT would continue to review whether an inmate involved in that regime should have items that could be used to self-harm removed.

138. Reference was made by some witnesses to the need to not undermine a prisoner's dignity by removing normal clothing from him. A smock is less dehumanizing than no clothes and allowing a prisoner to wear his own clothes is better still.

139. It was also suggested that the clinicians who had regular contact with David could have caused his shoe laces and pants drawstring to be removed had they concerns.

140. The belief that there were no hanging points in the MHU cells may have given false comfort about this issue.

141. It was also suggested that David had a history of self-harming through cutting rather than the use of ligatures and that as there were other items such as bedding in the cell that could be used by a prisoner intent on hanging himself there would be no point in just removing shoe laces or pant draw strings.

142. There was a deal of uncertainty as to whether an earlier local order continued to apply and changes have been made since David's death

Conclusion

143. David was transferred to the MHU because he was assessed as being psychotic. He was known to regularly refuse to accept psychotropic medication. He was clearly not stable and was very likely to undergo mood changes. He had a recent history of self-harming and making threats of self-harm.

144. In the circumstances the level of risk he posed to himself could not be precisely defined.

145. The management of such inmates requires balancing the risk they pose to themselves and others against the detrimental effect of minimising those risks by intensive observation and the withdrawal of access to personal items that can be used to self-harm.

146. That careful assessment did not occur in this case. No one made a considered assessment that the risk of allowing David to have access to ligatures was justified. This was a failure of the correctional officers and Justice Health officers responsible for managing the MHU.

147. Since David's death the policies in place at the Cessnock Correctional Centre have been amended to prohibit cords or drawstrings being allowed to inmates on RITs within the MHU or Multi-purpose Unit as it is now called. Accordingly, no further recommendation is required.

Monitoring of the cell camera

148. A review of the vision recorded by the camera in Mr Wotherspoon's cell showed that on the day he fatally self-harmed, he commenced efforts to obscure the camera with wet toilet paper at 3.06pm. The first attempt was unsuccessful. He made further attempts. The camera was partly obscured from about 3.15pm and remained so until David was found unconscious in his cell 3.35pm.

149. For the reasons detailed earlier in this report I conclude that contrary to her inquest evidence, the officer monitoring the cells did not notice this activity until moments before David was found. That is not surprising: the officer was expected to watch a wall of monitors showing up to 64 different views. That officer also had to take phone calls from all over the complex and respond "knock ups' from prisoners.

150. The officer on duty in the Monitor Room on the day in question was undertaking her first shift in that role. She told the inquest she had a small number of sessions watching another officer perform the function and helping out in the weeks before this incident.

151. The inadequacy of her training was highlighted when she was unable to activate the electronic locks to allow a senior officer who was finishing his shift to leave the centre. He came to the Monitoring Room and gave the officer further instruction in the technical aspects of her role.

152. The limited proficiency of the officer in the Monitoring Room was made significant at the material time because the MHU officers were in the process of delivering meals to the prisoners in the unit. As a result, they were away from their work station and thus unable to monitor the observation cameras as they would normally do at other times.

Conclusion

153. The responsibilities of the Monitor Room officer were unduly burdensome and the officer attempting to discharge them on the day in question had been inadequately trained.

154. Since earlier this year, two officers have been posted in the monitor room from 8.30am till 10.30pm. The second officer on the afternoon/night shift is a senior correctional officer who provides increased training for the junior staff and generally oversees the operation of the Monitor Room.

155. Further, a Monitor Room Standing Operating Procedure has been developed which includes a direction that staff initiate effective responses to alarms and incidents, including covered cameras. It also identifies that control room has the primary responsibility for monitoring assessment cells and staff in the control room are to alert unit officers of any need to intervene.

156. Provided that counsel assisting's suggestion that instructions be given as to what matters are to be recorded in a log kept in the Monitor Room is adopted, I am of the view that these changes adequately address the shortcomings highlighted in this case.

Contacting next of kin

157. Mr Wotherspoon Senior expressed his concern to investigators that he had not been rung by Corrective Services and told about what had happened to his son that afternoon.

158. Corrective Services policy requires that the "Emergency Contact" person nominated by an inmate at reception or as updated subsequently be contacted when an inmate is taken to hospital for admission. In this case Corrective Services records showed Ms Mason as the Emergency Contact.

Conclusion

159. So far as can be established, authorities contacted neither David's partner nor his parents when he was taken to hospital. However, his partner heard of the incident from a friend monitoring police radio broadcasts and she called the jail very soon after David was placed in the ambulance and before he had arrived at the hospital. She was apprised of what had transpired.

160. I accept that a parent does not have a definitive right to be advised of welfare and health issues if a prisoner has nominated somebody else as his contact person, as had happened in this case. I assume that the authorities would have contacted David's partner if she had not called first.

161. In any event, David's parents became aware of his situation. One would hope that adherence to bureaucracy would not have prevented Corrective Services from alerting them to their son's location had they not otherwise have been notified.

162. Accordingly, no adverse comment should be made and no recommendations for change are necessary.

Extent of the autopsy

163. There was no dispute as to the manner and cause of David's death among those who were aware of the facts until a forensic pathologist in private practice, Professor Johan Duflou, raised questions about those issues in a report he provided to solicitors acting for David's family.

164. The evidence has shown that those questions were baseless and indeed under close questioning from counsel assisting, Professor Duflou conceded that the manner and cause of death had been established to the requisite standard.

165. It became apparent that the on-going concern of Professor Duflou was the ordering of an external examination and a medical records review rather than the three cavity internal examination that he considered should have been undertaken in this case because the material events occurred while the deceased was in custody.

166. I am aware that some forensic pathologists do not agree with the move away from performing three cavity autopsies in almost all cases apparently involving an external cause of death.

167. However, the law in New South Wales reflects the more enlightened perspective that when it comes to examining and or dissecting the bodies of those whose deaths have been reported to a coroner, the dignity of the deceased is to be respected and the least invasive procedure that will enable the manner and cause of death to be established should be utilized.

168. Although conceding in his second report that intentionally self-inflicted hanging was "very likely" the manner of David's death, Professor Duflou continued to assert that a three cavity autopsy should have been performed because a NSW Health policy directive stipulated it should occur in relation to all deaths in custody cases. He also pointed out that was consistent with a protocol published by the International Red Cross.

169. The *Coroners Act 2009* in s. 88 stipulates that a person conducting an autopsy to establish the cause and manner of death "*is to endeavor to use the least invasive procedures that are appropriate in the circumstances."*

170. The provision is somewhat misconceived because the person conducting the autopsy can only examine the body to the extent authorized by the coroner who issues the autopsy order. The direction should perhaps also be directed to the coroner. Certainly in my experience, in accordance with the spirit of the law, coroners throughout NSW adopt this approach.

171. In this case the Newcastle Deputy State Coroner ordered an external examination of the body; analysis of ante mortem blood and a review of the hospital medical records, consistent with the recommendation made by the duty pathologist, Dr Lyons.

172. Dr Lyons explained the reason he made the recommendation in those terms. He said:

- As the death occurred 9 days after the fatal incident he expected that subcutaneous bruising would be apparent on external examination without the need for dissection.

- An MRI of Mr Wotherspoon's body had been performed at the hospital and was available to the case pathologist.

- The time between admission to hospital and death gave police far longer than usual to investigate the circumstances before the autopsy decision had to be made. Specialist death in custody detectives had been involved. They had no suspicions, labeled the death a suicide and indicated that police did not intend attending the autopsy all of which indicated police considered no third party was involved.

- The P79A contained significant detail.

- Old scars on Mr Wotherspoon's body suggested a history of suicide attempts.

- He was known to be suffering from mental illness.

- The medical records provided adequate information as to the cause of death.

173. The CCTV vision demonstrated that Mr Wotherspoon was alone in a locked cell when the fatal incident occurred and his actions in covering the cell camera were in the circumstances only explicable by an intention to self-harm. When the scene information was coupled with the information available from the hospital records, an external examination and toxicology, the manner and cause of death were readily apparent. No more invasive autopsy would have assisted the inquest reach the findings it was required to make.

174. A NSW Health Policy Directive (PD2012_049) entitled "Forensic Pathology – Code of Practice and Performance Standards in NSW" (the Code of Practice) acknowledges that *"There may be circumstances where departure from these standards is appropriate. The reasons for this should be clearly documented..."*

175. Appendix 9 of the Code of Practice is headed *Standard Guidelines: Deaths in custody.* It provides that in such cases *"The post mortem examination*

should be performed as for a homicide or suspicious death, with appropriate investigating police personnel and police photographers in attendance."

176. The other instructions make clear that it is envisaged an internal examination will usually be undertaken. However the Code of Practice also recognises the imperative of using the least invasive procedure to satisfy the needs of the coroner to make findings.

177. A NSW Health policy directive cannot override the coroner's autopsy order. Dr Cala, the forensic pathologist who undertook the autopsy, could not rely on the Code of Practice to undertake a more invasive autopsy than had been ordered. However, it calls into question whether Professor Lyons, the pathologist who recommended that the coroner issue the order in the terms that it was made, inappropriately failed to comply with the intent of the policy directive.

Conclusion

178. I am of the view the recommendation made by Professor Lyons was appropriate in the circumstances and was consistent with the legislative requirement to respect the dignity of the deceased and undertake the least invasive autopsy necessary to establish the manner and cause of death.

179. Professor Lyons' explanation for departing from the usual practice is set above. I consider the reasons he has given justify the departure from the policy as the policy allows.

180. Furthermore I consider his notation on the "Request for coronial direction" form adequately records his reason for the recommendation. While a literal reading of the Code of Practice would indicate that it is the autopsying pathologist who needs to record the reasons for departure from its guidelines that simply reflects the failure of that document to reflect the reality of practice.

181. In my view, it will rarely be appropriate to make a blanket ruling requiring the undertaking of any investigative step in every case within a category of coronial cases without considering the circumstances of each case. In my view the sound approach can be summed up by the maxim, "Do everything that is necessary but only what is necessary."

182. The policy directive is due to be reviewed later this year. That is timely. I assume the coroners will be consulted as part of that process and so I will refrain from making a formal recommendation as to how it might be updated.

Findings required by s. 81(1)

As a result of considering all of the documentary evidence and the oral evidence given 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 person who died was David William Wotherspoon.

Date of death

Mr Wotherspoon died on 14 April 2013.

Place of death

He died in the John Hunter Hospital at Newcastle, New South Wales.

Cause of death

The medical cause of his death was hypoxic encephalopathy caused by neck compression due to hanging.

Manner of death

David Wotherspoon died from injuries sustained nine days before his death when he deliberately tied a ligature around his neck and attached the other end to the door locking mechanism in his prison cell and suspended his weight from it with the intention of ending his life.

I close this inquest.

Magistrate Michael Barnes
State Coroner