STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of MC
Hearing dates:	15, 16, 17 & 24 August 2018
Date of findings:	31 August 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, Risk Intervention Team, Mental Health Screening Unit, risk assessment, step-down procedures, Management Plan, discharge planning
File number:	2015/155740
Representation:	Mr J Harris, Counsel Assisting, instructed by Ms K Hainsworth, Crown Solicitor's Office
	Mr L Brasch, instructed by the Office of the General Counsel, for Corrective Services NSW
	Ms H Cooper for Ms GG
	Mr C Jackson, instructed by Avant, for Dr N Phung
	Mr J Lawrence, instructed by Van Houten Law, for Mr H Bhalla
	Mr M Lynch, instructed by Hicksons Lawyers, for Justice Health & Forensic Mental Health Network
	Mr A Martin for Mr R Aleidzans
	Ms L Toose for RN G Breen and NUM S Momirovic

Findings: I find that MC died on 25 May 2015 at the Metropolitan Reception and Remand Centre, Silverwater NSW 2128. The cause of MC's death was hanging. MC died whilst in lawful custody as a consequence of actions taken by him with the intention of ending his own life.

Non-publication orders: Pursuant to section 74(1)(b) of the *Coroners Act 2009*, I direct that the following material is not to be published:

(a) From the coronial brief of evidence (Exhibit 1 tendered on 15 August 2018 (and the equivalent material in Exhibit 1 tendered on 2 March 2018)):

(i) Tab 25 Annexure F [13.3.2 OPM, 2017 version];
(ii) Tab 25 Annexure G [MRRC LOP 1.29];
(iii) Tab 25 Annexure H [MRRC LOP 2.06];
(iv) Tab 61 [13.3 OPM, unredacted 2007 version];
(v) Tab 69 [3.7 COPP, 2017 version];
(vi) Tab 37, paras [99] and [101] [DIC report];
(vii) Names and MIN numbers of inmates, other than MC, referred to in tabs 37, 41, 47, 49 and 55.

(b) Still images of the CCTV footage of the Metropolitan Reception and Remand Centre tendered on 16 August 2018 as Exhibit 2.

Recommendation: ***To the Commissioner for Corrective Services NSW; the Chief Executive, Justice Health & Forensic Mental Health Network; and the Governor, Metropolitan Reception and Remand Centre:***

I recommend that consideration be given to collaboratively developing and implementing Local Operating Procedures for the Metropolitan Reception and Remand Centre. The procedures specifically relate to inmates from the Mental Health Screening Unit (**MHSU**) who have been placed on a Risk Intervention Team (**RIT**) Management Plan. The procedures should address the following:

(a) Identify the circumstances in which a RIT should seek information from an inmate's Justice Health treating team in order to formulate a RIT Discharge Plan, particularly in situations where that inmate is placed in an assessment cell that is not within the MHSU;

(b) How information relevant to an inmate's RIT Discharge Plan is to be shared between the inmate's Justice Health treating team and a RIT; and

(c) The means by which any recommendation made by a psychiatrist that an inmate be subject to psychiatric review prior to discharge from a RIT Management Plan is to be communicated to a RIT.

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1. Introduction

1.1 Mr MC was being held in lawful custody in a NSW correctional centre at the time of his death. Shortly before his death MC had been identified as a person at risk requiring specialist mental health assessment. At around 7:00pm on 25 May 2015 MC was found unresponsive in his cell after having apparently taken his own life. Only eight hours earlier he had been reviewed by a specialist team that had been formed to make an assessment of whether MC was at risk of harm.

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 they 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 *Coroners Act 2009* 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. 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.

2.3 Inquests often have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

2.4 The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future.

2.5 If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

3. MC'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. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge MC's life.

3.2 MC was born in Brisbane in 1983 and had an older sister (D) and two younger sisters (A and A). He and his siblings were raised by their mother, TP, as MC's father was not present in his life. TP and her children later moved to the Gold Coast and then to Macksville when MC was about 8 years old.

3.3 MC went to primary school in Macksville and then high school, although he did not complete his secondary studies. Despite this, MC possessed a wide variety of skills that were self-taught and a product of his intelligence and talents. He was particularly adept at using computers and in the areas of automotive, and other, mechanics. He was known to regularly fix cars and bikes, and called it "bush mechanics".

3.4 In later life MC met Ms GG. After forming a relationship with her, MC moved to Port Macquarie to live with GG and her son, M. Eventually MC and GG had a daughter together, A. MC was the first person to hold A following her birth and this began an unbreakable and loving bond between father and daughter, a bond which GG describes as unlike any other that she has ever seen. It is perhaps only natural that such a bond existed as A, with her long curly red hair, bears MC's likeness as well as his mannerisms; she is truly her father's daughter.

3.5 MC was a devoted father not only to A, but also to M and to MC's son from a previous relationship, K. MC spent much time with each of them and was described by GG as a father who was very much hands-on and involved in his children's activities. There is perhaps no greater sign of the positive influence that MC had on his children than by the fact that M at a young age asked MC if he could call him "daddy". MC taught M to ride his first bike, and his first motorbike. After buying M his first motorbike he painted in in M's favourite colour and with his favourite number on it. This treasured item of M's is no doubt a physical reminder of the love and devotion that MC had for all of his children.

3.6 MC's relationship with GG and his children was focused on the simple, everyday aspects of life. GG describes herself and MC as homebodies, who enjoyed relaxing in each other's company at home as much as spending time with close family and friends. One of MC's favourite places was the beach and he would often go there to unwind. MC also loved all different types of animals, as shown by the many pets that he kept in his home. GG fondly recalls that MC particularly liked keeping fish and that at one stage their home was full of aquariums in the bedroom, lounge room and garage.

3.7 It is heartbreaking to know that at the time of his death MC was striving to overcome a number of personal issues that had resulted in his incarceration, so that he could build a life as a young

family with GG and their children. The loss that they have suffered, together with MC's mother and other members of his family, is enormous.

4. MC's custodial history

4.1 When he started high school MC first started smoking marijuana and soon afterwards began to display behavioural issues. A product of this was associating with negative peer influences and TP found MC's behaviour to be challenging. At around the age of 15 or 16 TP noticed that MC had developed paranoia. Shortly afterwards MC began using amphetamines.

4.2 MC first came into contact with the criminal justice system as an adult in 2003. After being charged with driving, drug-related, and assault offences MC was later charged with a more serious offence of violence in July 2003. He was later tried and convicted of this offence, resulting in a sentence of imprisonment. On appeal by prosecuting authorities, this sentence was later increased resulting in a term of 7 years 6 months, with a non-parole period of 4 years 6 months.

4.3 Following his release from custody at the expiration of this sentence MC continued to offend and to be found in breach of his parole conditions. Much of his offending was related to continued illicit drug use and resulted in the commission of varying offences of violence. This resulted in MC spending further periods in custody between 2008 and 2015.

4.4 Shortly after being released from custody MC returned to stay with his mother in March 2015. On 25 March 2015 TP woke up to find MC upset and crying, voicing suicidal thoughts and referring to using a knife to end his own life. TP attempted to seek assistance from the local police in order to have MC taken to hospital. However, MC was later involved in a police pursuit resulting in his arrest. He was subsequently refused bail at Coffs Harbour Local Court and on 26 March 2015 MC was received into custody a Grafton Correctional Centre (**Grafton**).

4.5 During an intake assessment at Grafton it was noted that MC had a history of mental health issues and making threats of self-harm; however, at the time of assessment there were nil signs or symptoms of either. Indeed, it was noted that MC appeared to be future focused and was guaranteeing his own safety.

4.6 On 3 April 2015 MC was transferred to Cessnock Correctional Centre (**Cessnock**).

5. MC's medical history

5.1 Following MC's arrest in 2003, a court-ordered psychiatric assessment was conducted by a psychiatrist who diagnosed MC as suffering from drug-induced psychosis (with a possible differential diagnosis of an illness such as schizophrenia), substance dependence, and alcohol abuse. Whilst in custody in 2003, MC was assessed by another psychiatrist who was concerned about MC having a possible persistent low-grade psychosis following on from his drug-induced psychosis, with a possible differential diagnosis of schizophrenia or schizoaffective disorder.

5.2 A further psychiatric review was performed by another psychiatrist in about January 2010. At this time, it was found that MC demonstrated no evidence of psychotic symptoms and that his presentation at the time of review, and in the previous four years, was inconsistent with a diagnosis of chronic schizophrenia. On this basis, it was considered that it was more likely that MC's past psychotic symptoms were related to substance abuse.

5.3 When MC was released from custody on 23 February 2015, TP noticed that he was displaying signs of extreme paranoia, saying that people wanted to kill him. After being arrested in March 2015 MC was further assessed and found to be neither paranoid nor mentally disordered. During a screening process when MC was accepted into custody at Grafton it was noted that whilst he appeared agitated, he was displaying nil symptoms relating to mental health, or self-harm, issues.

6. Events of 18 and 19 May 2015

6.1 Whilst in custody at Cessnock between 3 April 2015 and 17 May 2015, MC had a number of interactions with staff from Justice Health & Forensic Mental Health (**Justice Health**). He referred himself to a Justice Health clinic reporting that he was feeling stressed. He later attended the clinic and further reported experiencing auditory hallucinations for which he was prescribed anti-psychotic medication (olanzapine).

6.2 At Cessnock MC made a number of phone calls to both his mother and GG. As part of routine procedure at all correctional centres in NSW the calls were recorded. During a call recorded at 11:16am on 18 May 2015 MC told his mother that that he felt like other people were talking about him and that it was "*a big conspiracy*".[1] He also referred to other people pointing a gun, and to the fact that other people conspiring against him was like a puzzle.

6.3 During a subsequent call with TP at 1.32pm, MC referred to having a "*gut feeling*" that something was wrong, to other people "*hunting*" him, and to people putting "*a crane over in the yard at night…and they're gunna crane me out*".[2] TP attempted to reassure MC but he told her that he did not believe her and again referred to the existence of a "*big conspiracy*" and that he did not know what was going on.[3] TP told MC that she would attempt to arrange for him to be seen by a doctor.

6.4 In subsequent calls with his mother at 1:52pm and 2.37pm later that day, MC again referred to the existence of a conspiracy and subliminal messages[4], and spoke again about a crane.[5] In other calls with GG at 2:54pm and 3:11pm on the same day MC also referred to the existence of a conspiracy, referred to the crane, and said that he was "*spinning out*".[6] GG also attempted to reassure MC by informing him that she had contacted his solicitor to assist with a request to have MC transferred to Long Bay Correctional Centre (**Long Bay**).

6.5 The concerns expressed by TP and GG resulted in MC's solicitor sending an email to Emma Smith, a Client Liaison Officer with Justice Health. The email indicated that MC's mother had formed the view that MC was psychotic, delusional and anxious and on this basis she was requesting that he be transferred to Long Bay. Ms Smith later called TP to acknowledge that she had received the email, and then forwarded the email to the Nursing Unit Manager (**NUM**) at Cessnock for further action to be taken, and to seek MC's consent for information to be provided to his mother. Later that evening MC was noted to be behaving in an angry and aggressive manner and was consequently placed in a detox cell.

[1] Exhibit 1, page 485.
[2] Exhibit 1, page 488.
[3] Exhibit 1, page 490.
[4] Exhibit 1, page 492.
[5] Exhibit 1, page 496.
[6] Exhibit 1, page 500.

6.6 The following day, 19 May 2015, Ms Smith received MC's written consent and an email from the NUM at Cessnock. Following a review conducted by a Justice Health mental health nurse at around midday, it was noted that MC had indicated that he had not been taking his medication for three days and that he was voicing paranoid thoughts, but not making any threats of self-harm. Due to MC's presentation, his assessed level of risk was changed, he was moved to a camera cell to allow for frequent observations, and he was placed on a Risk Intervention Team (**RIT**) protocol. A RIT protocol provides an interdisciplinary mechanism for staff from both Corrective Services NSW (**CSNSW**) and Justice Health to identify, assess and intervene when an inmate is at risk and/or making self-harm attempts.[7] The aim of placing an inmate under a RIT Protocol is to assess an inmate's risk factors, ensure the inmate's safety, ensure the effective development and implementation of an individual management plan, to ensure appropriate specialise referral where applicable, and to provide continuity of crisis and case management care.[8]

6.7 MC was also referred to the Mental Health Screening Unit (**MHSU**) at the Metropolitan Reception and Remand Centre (**MRRC**). He was later accepted into the High Dependency Unit (also known as pod 21) of the MHSU, with arrangements made for him to be seen by a psychiatrist.

7. Events of 21 May 2015

7.1 On 20 May 2015 the RIT protocol that MC was under was terminated in order to allow for his transfer from Cessnock to the MRRC. The following day, 21 May 2015, MC was received in the MHSU where he was seen and assessed by Dr Nhut Xan Phung, a psychiatry registrar. Dr Phung was one of two psychiatric trainees employed within the MHSU at the time.

7.2 Dr Phung conducted an initial psychiatric interview to begin the process of assessing MC (a process which was expected to take a number of days to weeks) and to treat his psychosis. Dr Phung formed a provisional diagnosis that MC was experiencing a psychotic episode due to a relapse of schizophrenia, with a differential diagnosis of drug-induced psychosis. Dr Phung described MC's mental state at the time as "*characterised as having a blunted affect, a slightly depressed mood, a reduced quantity and rate of speech, an impoverished thought form with relatively little spontaneous communication and expressed thought*".[9] Dr Phung noted that MC's thought content suggested he had persecutory ideation and that he had been experiencing auditory hallucinations, which had become a humming noise or mumbling in recent weeks.

7.3 Dr Phung made a recommendation for MC to be admitted to pod 21 of the MHSU, which was the acute observation pod which offered the highest level of monitoring available in the MHSU at the time. Dr Phung noted that from the time of MC's release from the earlier RIT protocol at Cessnock up until his assessment in the MHSU, there had been no further reports of self-harm or self-harming behaviours. Dr Phung made an assessment that MC was at medium risk of harm to others and a low risk of suicide.[10] He also noted that MC's risk was likely to be highly changeable, that he was in an at-risk mental state and that there had been concern from others about risk. Finally, Dr Phung commenced MC on quetiapine (an anti-psychotic medication).

7.4 The initial management plan for MC was for him to remain in pod 21 and be housed in a one-out cell, meaning that MC would be the only occupant of the cell. He was transferred to pod 21 and

[7] Exhibit 1, page 555.
[8] Ibid.
[9] Exhibit 1, page 207 at [1.9].
[10] Exhibit 1, page 208 at [1.11].

later seen by Enrolled Nurse (**EN**) Paul McNulty at around 6:00pm who noted that MC did not present at that time as being depressed, anxious, worried or unduly distressed.[11] EN McNulty also noted that MC did not verbally express any ideas or suggestions that he might be at risk.

8. Events of 22 May 2015

8.1 Registered Nurse (**RN**) Edwin Coronel was the Justice Health nurse allocated to care for MC on 22 May 2015. RN Coronel did not see MC displaying any unusual behaviour in the morning at breakfast but later spoke to MC and noted that he appeared agitated. MC said that a group of people had been hunting him and were going to kill him. RN Coronel reassured MC by telling him that he was in a safe environment and offered him some medication to settle his anxiety. However, MC refused the medication because he thought it would make him vulnerable and "*easily ganged up on*" by five people if he was sedated. MC did agree, though, to being interviewed by a RIT later that day.

8.2 MC later called his mother at about 9:19am. He told TP that he had seen the father of the victim of the offence he was charged with in 2003, and that this person was at the gaol the previous evening. In a later call to GG at 9:40am MC said that someone was hunting him. During a number of further calls between about 10:00am and 12:43pm MC made further references to a conspiracy and others wanting to harm him. During these calls both TP and GG continued to attempt to reassure MC and tried to convince him to take his medication. At around 10:00am, in between these phone calls, MC returned to the medication dispensary room in the Justice Health clinic in an agitated state. He complained that people were hunting him. RN Coronel again attempted to reassure MC and offered him medication; again, MC refused it.

8.3 Following the phone calls TP and GG both called Ms Smith separately to advise that MC had said that a person was coming to kill him. Ms Smith conveyed this information to the NUM at the MHSU, Sandra Momirovic.

8.4 At about 1:00pm NUM Momirovic told RN Coronel that she had received a call from Ms Smith and been told that MC's mother and partner had called to advise that MC had been threatening to kill himself. NUM Momirovic also advised RN Coronel that MC had told his mother that he had thoughts that he was going to be killed by another person. NUM Momirovic asked RN Coronel to document this information on MC's medical record and on the daily clinical handover sheet. Further, NUM Momirovic sent an email to other personnel to relay this information. NUM Momirovic asked RN Coronel to initiate a RIT for MC until a comprehensive risk and mental health assessment could be conducted, whilst at the same time requesting that a doctor on site attend to review MC.

8.5 Maggie Cruickshank, a psychologist from the MHSU, RN Coronel and a CSNSW Assistant Superintendent went to see MC in his cell a short time later. According to a retrospective note made by Ms Cruickshank dated 26 May 2015, MC presented as paranoid and appeared angry and agitated. He denied that he had told any family members about any intent to self-harm, and denied any such thoughts or intent to those interviewing him. He expressed the belief that he was in danger from others and said that the attending staff were attempting to "*set him up*". Further, he believed that being placed in an observation cell would increase his access to others who he believed wanted to harm him.

[11] Exhibit 1, page 192 at [8].

8.6 Those interviewing MC determined that because of MC's apparent paranoid mental state and agitated presentation he should be placed on a RIT protocol for his protection. RN Coronel created a Health Problem Notification Form (**HPNF**) with instructions for CSNSW officers to place MC in a safe cell with no sharps.[12] As there were no safe cells available in the MHSU at the time MC had to be transferred to the Darcy pod, a different location within the MRRC, where a safe cell was available. This was routine practice when a safe cell was unavailable in the MHSU.[13] Shortly before 3:00pm, MC was transferred to Darcy pod 1 in safe cell number 38.

8.7 At about 3:30pm Dr Phung went to the Darcy unit in order to provide a handover to the staff there regarding MC, and to review MC himself. Dr Phung noted in MC's medical records that his mother had expressed concerns for his welfare, and that MC was in an agitated state and openly expressing persecutory fears.[14] Dr Phung noted that as MC's transfer occurred on a Friday afternoon, the only Justice Health staff available in the Darcy unit was MC's primary care nurse; there were no Darcy unit psychiatrists or mental health nurses available at the time (as the day shift had ended at 3:00pm). Dr Phung wrote "*Placed on RIT*" in the progress notes for MC's Justice Health medical file and spoke to a CSNSW officer within Darcy to ensure that MC was placed in a camera cell and that safe cell conditions had been initiated. As a HPNF had already been created by RN Coronel, no further written instructions were provided to CSNSW staff.

9. Events of 23 and 24 May 2015

9.1 At around 10:30am the following day, 23 May 2015, MC was reviewed by a RIT comprised of Assistant Superintendent (**AS**) Harry Bhalla, RN Geraldine Breen and a CSNSW Service and Programs Officer (**SAPO**), Suzanne Foster. It was noted that whilst MC said that he had been eating and sleeping well, he continued to display paranoid thoughts, said that he did not understand why he was in the MHSU, and complained that there was "*morse code in his head, lots of banging*".[15] RN Breen noted that MC was cooperative and compliant, but she formed the view that MC was guarded in answering questions about psychotic symptoms.[16] She also noted that MC denied any suicidal ideation and repeatedly said that he would not harm himself.

9.2 The RIT assessed MC as being a medium risk of harm to himself, and a low risk of harm to others. The team decided to keep MC under a RIT protocol, to allow time for his medication to take effect, and he was placed on a waitlist for follow-up and to be reviewed in two days' time.[17] Accordingly, MC was placed on focused case management and housed in a one-out safe cell.

9.3 Following the RIT review MC called his mother at 10:43am. He asked her if she had called the gaol and reported that he was suicidal resulting in him being placed on a RIT. When TP confirmed that she had called Ms Smith this seemed to anger MC and he again referred to others wanting to harm him whilst he was locked in a cell and unable to defend himself.[18]

9.4 The next day, 24 May 2015, MC called his mother again at around 11:00am. He again voiced paranoid thoughts and referred to a belief that something would happen to him in the next few days. On this basis he asked that his family visit him before it was too late. When TP indicated that she could visit MC the following weekend he replied, "*I don't even think I'll last that long*".[19]

[12] Exhibit 1, page 197 at [14]-[15].
[13] Exhibit 1, page 203 at [23].
[14] Exhibit 1, page 208 at [1.13].
[15] Exhibit 1, page 186.
[16] Exhibit 1, page 194 at [7].
[17] Exhibit 1, page 90 at [9].
[18] Exhibit 1, page 530.
[19] Exhibit 1, page 537.

10. Events of the morning of 25 May 2015

10.1 Sometime during the morning of 25 May 2015 TP called Ms Smith and told her that during a phone call with MC he had said that someone was going to kill him. At about 9:00am TP made a further call to the MRRC Chaplain, Elizabeth Lee. During the call of about five minutes, MC's mother said that she was concerned about MC's mental health and that the previous week he had told her that he had seen people from his past who were deceased as if they were still alive. Ms Lee told TP that she would do her best to follow up and check in on MC in the afternoon.

10.2 At around 10:30am Ms Smith sent NUM Momirovic an email in which she said that she had received a further call from MC's mother who was crying and worried at the time. Ms Smith said that MC had called his mother and told her that he thought someone was going to kill him, and asked NUM Momirovic for an update on MC's condition. NUM Momirovic replied to Ms Smith by email at around 10:53am and said that MC was in a safe cell in Darcy and that she would obtain some feedback after the RIT reviewed him later that day.

11. The RIT assessment on 25 May 2015

11.1 A RIT saw MC between about 11:00am to 11:30am. The team was comprised of AS Bhalla, RN Patricia Guilfoyle and SAPO Ralfs Aleidzans. AS Bhalla noted that the RIT had not received any adverse reports in the period between when MC last seen by a RIT on 23 May 2015 up until the time of review on 25 May 2015. AS Bhalla described MC's presentation as "*good*" and that "*he was future focused and he wanted to have more contact with his family*".[20] AS Bhalla also noted that MC was cooperative and guaranteed his own safety.

11.2 RN Guilfoyle noted that MC said that he had been eating and sleeping well, but that he was anxious to be out of the safe cell. She said that MC assured the RIT that he had no thoughts of self-harm and denied telling his mother, or anyone else, that he had thoughts of harming himself.[21]

11.3 Mr Aleidzans described MC's presentation as being co-operative, appropriate and calm. He said that MC was communicative and denied any current or history of self-harm or suicidal ideation. Further, he said that MC guaranteed his own safety and appeared to be positive and future-orientated. He said that MC told the RIT that he had been eating and sleeping well and that he rated his mood as 8 out of 10. Finally he noted that MC was not displaying any psychotic symptoms.

11.4 Following the interview Mr Aleidzans said that he and the other members of the team discussed MC's case and developed a management plan. The team concluded that MC was a low risk of self-harm and on this basis terminated the RIT protocol that MC was on. It was noted that MC was suitable for normal cell placement, meaning that he could be placed in a cell alone (one-out) or in a cell with another inmate (two-out). However given that MC had originally been transferred from the MHSU to Darcy pod due to a lack of cell availability, it was noted that he was to remain in Darcy until a bed was available for him in pod 19 or 20 in the MHSU.[22]

[20] Exhibit 1, page 90 at [10].
[21] Exhibit 1, page 190 at [9].
[22] Exhibit 1, page 76 at [12].

12. Events on the afternoon of 25 May 2015

12.1 At 1:07pm MC was moved from cell 38 in Darcy pod 1 to cell 64. He later spoke to his mother and GG on the phone at 1:52pm and 2:09pm, respectively. In both calls, MC told TP and GG that he loved them. During his call with his mother MC said that he did not need to take his medication and that there was nothing wrong with him.[23] During his call with GG MC maintained that there was nothing wrong with him, but indicated that he had taken his medication.[24]

12.2 MC later met with Ms Lee at about 2:20pm after she had noted that MC had earlier been cleared from the RIT protocol following review, and made arrangements for him to see her in her office. Ms Lee noted nothing unusual about MC's presentation other than he was barefoot when he came to see her. She also noted that MC appeared a bit sullen or sad (which was not remarkable) but that his posture changed and he seemed more relaxed after she introduced herself. Ms Lee explained to MC that she had asked to see him because his mother had rung and was concerned about him. MC smiled, said that he was good and later asked Ms Lee if she would say a prayer for him. Ms Lee did so and noted that MC "*appeared in a good space*" at the end of the prayer.[25]

12.3 Following the prayer Ms Lee asked if there was anything else she could do for MC. He asked if he could speak with his mother. Although Ms Lee did not routinely make calls on behalf of inmates she agreed to do so in this case and called MC's mother. MC spoke to his mother for about five minutes. Ms Lee recalls that the conversation was supportive, that MC told his mother he was fine, and that it appeared that MC was providing as much encouragement and support to his mother, as she appeared to be providing to him. MC concluded the call by asking his mother to book a visit with him on the weekend and told his mother that he loved her.

12.4 Ms Lee had a brief follow-up conversation with TP during which she told her that she thought that MC was doing quite well. TP reiterated her concerns for MC but thanked Ms Lee for following up with him. Ms Lee told MC that she would follow up if his mother had any further concerns and told MC that he could also ask to see her again in the future for ongoing support. MC left Ms Lee at about 2:34pm and returned to the pod. Once there MC made a final call to GG at 2:36pm, during which he again repeated that there was nothing wrong with him and that he was not suicidal.[26]

12.5 By the afternoon of 25 May 2015 NUM Momirovic had not received any feedback regarding the outcome of the RIT review of MC. She noted that according to computer records MC remained on an active RIT protocol within Darcy. Accordingly, at 2.57pm NUM Momirovic sent an email to a Clinical Nurse Consultant within Darcy requesting an update regarding MC's status.

12.6 At 3:13pm MC left the phone area within the pod and returned to his cell, where he was later locked in at 3:14pm.

12.7 At about 7:05pm CSNSW officers Falanisisi Setefano and Miram Ram conducted a medication round with RN Bernadette Timms so that medication could be dispended to inmates in their cells. Officer Setefano opened MC's cell so that his medication could be given to him, and found that MC was sitting with his back against the cell bench facing towards the door. Officer Setefano then noticed that there was a green sheet wrapped around MC's neck which was attached to the

[23] Exhibit 1, page 539.
[24] Exhibit 1, pages 544, 545.
[25] Exhibit 1, page 114.
[26] Exhibit 1, page 547.

bars over the cell window. Officer Setefano immediately told Officer Ram to call for assistance whilst he removed the sheet from MC's neck, placed him on the ground, and commenced cardiopulmonary resuscitation. Emergency services personnel arrived at the cell at 7:22pm and continued the attempts to resuscitate MC. However these attempts were unsuccessful and MC was pronounced life extinct by attending paramedics at 7:44pm.

13. What was the cause and manner of MC's death?

13.1 MC was later taken to the Department of Forensic Medicine at Glebe where a postmortem examination was performed by Dr Issabella Brouwer, forensic pathologist, on 26 May 2015. Dr Brouwer noted that there was no clear ligature mark present apart from some faintly visible abrasions on the front and left side of the neck. A full body CT scan showed possible fractures of the thyroid cartilage in the neck. Dr Brouwer concluded in her autopsy report dated 6 April 2016 that the cause of MC's death was in keeping with hanging.[27] Having regard to the circumstances in which MC was found, the absence of any other identified anatomical or toxicological cause of death, and Dr Brouwer's opinion, I conclude that the cause of MC's death was hanging.

13.2 Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Taking into account MC's history of previous suicidal ideation prior to his last period in custody and the circumstances in which he was found on 25 May 2015, I conclude that the evidence is sufficiently clear, cogent and exact[28] to allow a finding to be made that MC died as a consequence of actions taken by him with the intention of ending his life.

14. What issues did the inquest examine?

14.1 Given MC's transfer from the MHSU to Darcy unit, and the proximity between MC's discharge from the RIT protocol on 25 May 2015 and his subsequent death, the coronial investigation into MC's death focused on three main issues:

(a) The adequacy of the psychiatric assessment and review that was conducted after MC was transferred to the MRRC;

(b) The adequacy of the assessment performed by the RIT on 25 May 2015; and

(c) The appropriateness of discharging MC from the RIT protocol on 25 May 2015.

14.2 In order to seek clarification of these issues, expert opinion was sought from an independent consultant psychiatrist, Dr Yvonne Skinner. In consideration of each of the above issues, Dr Skinner prepared three expert reports, which formed part of the brief of evidence, and also gave evidence during the inquest.

14.3 Each of these issues is considered in further detail below.

15. Was MC provided with adequate psychiatric assessment and review following his transfer to the MRRC?

[27] Exhibit 1, tab 4.
[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

15.1 In evidence Dr Phung explained that he did not expect, from a psychiatric point of view, to be able to gather every piece of important information from MC during his initial 90 minute assessment on 21 May 2015. Dr Phung explained that it was necessary to observe MC's mental state over a period of time – to observe longitudinal patterns – and to assess MC's response to treatment. Further, Dr Phung said that a period of time was required to monitor MC's response to a medication regime which would necessarily require adjustment as the effects of the medication, which might take days or weeks to have effect, were assessed.

15.2 Dr Phung agreed in evidence that the risk of suicide or self-harm cannot be accurately predicted and that classification of a person being at low, medium or high risk does not offer any absolute predictive power. He explained that he himself did not find such risk categories to be helpful and instead offered the opinion that it is more helpful to consider what may be done operationally in order to best assist a patient. However, Dr Phung agreed that there were a number of features of MC's presentation that placed him in a high risk group, namely his possible psychotic illness and the fact that he was incarcerated. Dr Phung explained that whilst on 21 May 2015 he was still in the early stages of forming a diagnosis for MC, he considered MC to be at low risk of self-harm because he denied any thoughts of self-harm and MC's past history did not suggest that he was at any higher level of risk.

15.3 In her first report Dr Skinner concluded that the initial assessment performed by Dr Phung was appropriate and adequate. However, Dr Skinner noted that it did not appear that Dr Phung had made any written note regarding follow up, setting out a plan for psychiatric review, and any relevant recommendations.[29] Further she offered the opinion that as Dr Phung had made changes to MC's medication regime by increasing it, and being aware of concerns expressed by MC's mother, the follow up should have included a plan for review by a psychiatrist to monitor MC's response to the medication and any possible side effects.[30]

15.4 The matters raised by Dr Skinner were considered by Dr Phung who provided a supplementary statement in response to them prior to the inquest. Dr Phung said that it was unclear how long MC would remain in Darcy but that it was his expectation that MC would remain there with safe cell conditions in place until he could be returned to an available camera cell in the MHSU. Dr Phung said that it was his expectation at the time of MC's transfer on 22 May 2015 "*that safe cell conditions would not be removed without further psychiatric review*".[31] On reflection Dr Phung explained that he was aware that a RIT is ultimately responsible for determining whether to discharge an inmate from a camera cell (and conferring with medical staff as they see fit). However, Dr Phung conceded that it would have been helpful to record a request in MC's progress notes that MC should be reviewed by a psychiatrist before he was discharged from a camera cell with safe cell conditions.[32] In evidence Dr Skinner explained that such a request need not have been lengthy and could have been done by noting a single sentence on MC's progress notes.

15.5 **Conclusion:** Dr Phung's psychiatric assessment of MC was appropriate and adequate in the circumstances of Dr Phung seeing MC for the first time. The assessment of 21 May 2015 represented an initial step in a diagnostic and treatment process that was expected to take days to weeks. The expert evidence from Dr Skinner does not suggest anything to the contrary other

[29] Exhibit 1, page 240.
[30] Exhibit 1, page 240.
[31] Exhibit 1, page 209D at [17].
[32] Exhibit 1, page 209D at [19].

than to observe that Dr Phung should have made a note setting out a plan for further psychiatric review. Such a note could have been easily made in a brief, but effective, form in MC's progress notes.

15.6 This was particularly important given that in his risk assessment of MC Dr Phung had noted that MC's level of risk appeared to be highly changeable[33] and in the context where Dr Phung had made a change to MC's medication regime. Having had an opportunity to reflect upon the observation of Dr Skinner in this regard, Dr Phung made the frank and fair concession (both before, and during, the inquest) that it would have been helpful to request that MC be reviewed by a psychiatrist prior to his release from a camera cell with safe cell conditions. In this sense it should be acknowledged that based on his experience of working in the MHSU, Dr Phung had an expectation that in the ordinary course of events a RIT would contact him prior to releasing an inmate from a RIT protocol.

16. Was the assessment conducted by the RIT on 25 May 2015 adequate?

16.1 In her first report Dr Skinner observed that whilst Justice Health staff made adequate reference to MC's previous Justice Health, and other, medical records, this information was not conveyed to the RIT that reviewed MC on 25 May 2015. As a result, the RIT did not refer to MC's previous medical history and do not appear to have taken into account the following factors:

(a) That MC had been transferred from Cessnock to the MHSU for psychiatric assessment due to the concerns of CSNSW staff;

(b) That MC's mother had expressed concerns about his potential to self-harm; and

(c) That MC was to be assessed in the MHSU and that he was only in Darcy because there was no suitable bed available in the MHSU.[34]

16.2 Dr Skinner opined that the above factors ought to have alerted the RIT to the need for continued observation of MC.

16.3 Given the opinion expressed by Dr Skinner, it was necessary during the inquest to examine what information the members of the RIT had regard to before the decision was made jointly to discharge MC from the RIT protocol. In this regard the evidence given by RN Guilfoyle is of critical importance.

Information available to the RIT members

16.4 AS Bhalla, as the RIT coordinator, said that he reviewed MC's CSNSW case management file prior to the review and also checked whether any case notes, alerts, or incidents had been created for him. Similarly, Mr Aleidzans said he reviewed MC's case management file for about five minutes prior to the review commencing.

16.5 AS Bhalla agreed that he was aware of the contents of the Mandatory Notification Form completed at on 22 May 2015 after MC had been reviewed at 1:30pm by RN Coronel, Ms Cruickshank and an Assistant Superintendent. That form noted that MC had made a threat of

[33] Exhibit 1, page 670.
[34] Exhibit 1, pages 240-241.

self-harm to his mother and partner.[35] AS Bhalla agreed in evidence that he understood that the apparent threat had been reported by MC's mother, but said that it was not usual practice to contact the person who had reported such a threat. He explained that, for reasons of confidentiality, to do so would require authority being given by the inmate who reportedly had made the threat. When asked if the RIT discussed with MC whether he was content for his mother to be contacted regarding this issue AS Bhalla said that the team could ask MC about the matter directly without needing to speak to his mother.

16.6 RN Guilfoyle said that it was her usual practice, as a member of a RIT, to collect an inmate's Justice Health file from medical records on the morning of a RIT review and familiarise herself with the relevant and most recent parts of it prior to the review itself. On the morning of 25 May 2015 RN Guilfoyle followed this practice but when she went to collect MC's physical file from medical records at about 8:00am she discovered that it had already been collected and was with a Drug and Alcohol nurse. By the time the RIT was ready to review the first inmate at 8:30am that morning, RN Guilfoyle had not had an opportunity to retrieve the file. However, she was aware that the file was with a Drug and Alcohol nurse in a room next door to where the RIT review was occurring.

16.7 At 11:00am AS Bhalla indicated that MC was the next inmate to be reviewed. As Bhalla left the interview room in order to bring MC from his cell. RN Guilfoyle said in evidence that at this point she realised that she still did not have MC's file and informed the other team members of this. She said that she went next door to look through the files in the possession of the Drug and Alcohol nurse in the adjacent room but could not find MC's file. As the Drug and Alcohol nurse was interviewing another inmate at the time, RN Guilfoyle said that she was loathe to interrupt the interview in order to ask where MC's file was. Instead she returned to the RIT interview room without it. Upon her return RN Guilfoyle said that she took a blank progress note page in order to make notes of the review which she intended to later transcribe into MC's file once she obtained it. She also said that she had a brief opportunity to ask Mr Aleidzans about how long MC had been placed on a RIT protocol and the reason for it. As Mr Aleidzans was in the midst of providing this information, MC arrived in the interview room with AS Bhalla and the review commenced.

16.8 At the end of the review AS Bhalla left the room with MC to arrange for him to be returned to his cell. At this point, RN Guilfoyle said that she returned to the adjacent room and asked the Drug and Alcohol nurse where MC's file was. It was found under another inmate's file and RN Guilfoyle explained that this was why she was unable to locate it before MC's review began. After returning to the interview room with MC's file RN Guilfoyle said that she had an opportunity to review the most recent progress notes in the file before AS Bhalla returned to the room. At this point the team members discussed whether MC should remain on, or be discharged from, the RIT protocol.

16.9 RN Guilfoyle said that after the team had completed reviewing all of the inmates who were to be seen on 25 May 2015 she commenced transcribing the notes she had taken during MC's review (which had been written on the blank, single-page progress note) into his progress notes in the Justice Health file. RN Guilfoyle's transcription only notes the date and time of the review, and the members of the RIT.[36] No detail is provided regarding the review itself. Further, the transcription appears out of chronological sequence, following a progress note entry made on 23

[35] Exhibit 1, page 351.
[36] Exhibit 1, page 710.

January 2015. RN Guilfoyle sought to explain in evidence that she had started the process of transcription and then became distracted for reasons that she could not recall. As a result, she said that she slipped the single-page note of the review in MC's file, intending to complete the transcription at a later stage. However, she did not do so and the single-page note has not been subsequently located.

16.10 If the correct chronological order of progress notes had been maintained RN Guilfoyle's partial transcription should have followed the entry made by RN Breen on 23 May 2015. On this basis RN Guilfoyle was asked whether it was possible that she had not seen the entry made by RN Breen at all. RN Guilfoyle maintained that she did see the entry.

16.11 To summarise her evidence, RN Guilfoyle was asked specifically about what information she had prior to the team making such a determination. She indicated that the totality of the information available to her comprised the information gathered from MC during the review, the progress note written by RN Breen on 23 May 2015, and information from the CSNSW case management file which had been conveyed to her verbally by Mr Aleidzans.

16.12 This was RN Guilfoyle's position at the conclusion of questions asked by Counsel Assisting. Later in evidence, however, RN Guilfoyle's position changed. Counsel for Dr Phung suggested to RN Guilfoyle that, knowing the sessions being conducted by the Drug and Alcohol nurse next door were confidential nature, it was unlikely she would have "*raced*" into the room to retrieve MC's file as she had indicated in her earlier evidence. This suggestion appeared to cause some doubt in RN Guilfoyle's mind about the accuracy of her recollection of the event. She subsequently acknowledged that it was possible she was misremembering what had actually occurred. Further, RN Guilfoyle agreed that it was possible that she did not have MC's file at all at the point in time when the team made its decision to release him from the RIT protocol.

16.13 In evidence RN Guilfoyle agreed that when making a decision regarding an inmate's RIT protocol status it would be best practice to be familiar with the contents of that inmate's Justice Health file. Similarly, RN Guilfoyle agreed that it would have been preferable if she had been able to read Dr Phung's mental health assessment of 21 May 2015. RN Guilfoyle agreed that that the option to postpone MC's review until she had had an opportunity to review his Justice Health file was available to her. However, she could not recall why she did not utilise this option; in hindsight, she agreed that she should have.

16.14 Further, RN Guilfoyle said that she thought that she had mentioned the absence of the file in a statement which she made to investigating police dated 19 December 2016. When it was explained to RN Guilfoyle that she had not done so she said that it was quite remiss of her. RN Guilfoyle also said that she could not recall whether she had told her immediate superior, NUM Momirovic, on 26 May 2015 about the unavailability of MC's file but agreed that she had the opportunity to do so. Instead, RN Guilfoyle said that the only person she did inform was a "*senior staff*" person who was visiting Justice Health on 26 May 2015.

16.15 In evidence Dr Skinner was asked to assume that the RIT members had the following information available to them: TP reporting her concerns about MC harming himself, the contents of the CSNSW case management file, enquiries made with the CSNSW officers in the pod where MC was housed with nothing adverse reported, and the Justice Health nurse having no access to the Justice Health file before the interview started and either only limited or no reference to it before the decision was made to discharge MC from the RIT protocol. Dr Skinner

that the totality of this information would not have allowed for an adequate assessment to be done as no regard was had to the assessment conducted by Dr Phung. This assessment noted that MC was suffering from psychotic symptoms and indicated that MC's medication regime had changed. Further, Dr Skinner explained that it was important to refer to the Justice Health file because it would have given insight into MC's personality, his impulsivity, the fact that he would sometimes be more communicative but at other times he would be less forthcoming and be fearful of being harmed.

16.16 **Conclusion:** The totality of RN Guilfoyle's evidence raises considerable doubt as to whether any of the relevant information contained in MC's Justice Health file was available to the members of the RIT prior to them making the decision to discharge MC from the RIT protocol. The concession made by RN Guilfoyle that it was possible she did not have access to MC's file at all was entirely inconsistent with her earlier evidence that she did in fact have access to it. Further, it appears that RN Guilfoyle specifically did not have regard to the progress note entry made by RN Breen on 23 May 2015. RN Guilfoyle's partial transcription of the notes of the review out of chronological order, and the overall inconsistency of RN Guilfoyle's evidence, supports this conclusion. It should be noted that neither AS Bhalla nor Mr Aleidzans had any recollection of RN Guilfoyle indicating that she did not have MC's file, or of her leaving the interview room in order to retrieve it. Taking these matters into account, the evidence given by RN Guilfoyle regarding the availability of, and access to, MC's Justice Health file is unreliable and cannot be accepted.

16.17 The effect of this is that the RIT members were not in possession of important information contained in the file that was relevant to the decision which the team was required to make on 25 May 2015. Specifically, the RIT members did not have an opportunity to adequately consider the following: the assessment made by Dr Phung on 21 May 2015 that MC's level of risk appeared to be highly changeable[37]; the further assessment made by Dr Phung on 22 May 2015 that MC showed no insight and impaired judgment[38]; and the assessment made by RN Breen on 23 May 2015 that MC showed poor insight.[39] Without this information, as Dr Skinner noted, the RIT would have been unable to make an accurate assessment of MC, and in particular his degree of impulsivity.

16.18 RN Guilfoyle readily acknowledged that it would have been in accordance with clinical best practice for her to be familiar with the relevant portions of MC's file. The evidence does not establish that such a practice was followed on 25 May 2015. Further, no adequate explanation was offered by RN Guilfoyle as to why she did not request that MC's review be postponed, an option that was readily available to her. Indeed, AS Bhalla said that he would have expected the review to be postponed in such circumstances. Mr Aleidzans said that whilst he had never been part of a RIT review where a Justice Heath nurse member did not have an inmate's file, he had experience of RIT reviews being postponed. Taking into account each of these identified deficiencies regarding the RIT assessment conducted on 25 May 2015 leads to the conclusion that the assessment was inadequate.

Availability of information from MC's mother

16.19 Apart from the above information being unavailable to the RIT on 25 May 2015, it also appeared that the RIT was unaware that MC's mother had called Ms Smith that same morning. In her call

[37] Exhibit 1, page 670.
[38] Exhibit 1, page 690.
[39] Exhibit 1, page 691.

TP reported that MC had told her that someone was going to kill him. Ms Smith notified NUM Momirovic about this via an email sent at 10:30am, which NUM Momirovic replied to at 10:53am.[40] In that email NUM Momirovic indicated that she would "*get some feedback from the RIT*" when they reviewed MC. In the statement which she provided to police NUM Momirovic indicated that she could not recall who she spoke to on 25 May 2015 regarding Ms Smith's email.

16.20 This issue was explored with NUM Momirovic in evidence. She initially said that after reading Ms Smith's email she thought she had rung the Darcy unit and spoken to RN Guilfoyle. However, NUM Momirovic said that when she spoke to RN Guilfoyle on 26 May 2015 RN Guilfoyle told her that she had not mentioned Ms Smith's email. According to NUM Momirovic, this conversation left her "*stumped*" as to who she had spoken to. Later in evidence NUM Momirovic said that she could not remember who she had spoken to agreed that she could not say with any certainty that she had spoken to RN Guilfoyle. Eventually, NUM Momirovic acknowledged that she could not say at all if she did, or did not, pass on the report from TP that was contained in Ms Smith's email.

16.21 RN Guilfoyle said that she had no recollection of being made aware by NUM Momirovic (or anyone else) that TP had called on the morning of 25 May 2015 expressing concern for MC. RN Guilfoyle said that she recalled only being made aware of this fact when speaking to another staff member the following day on 26 May 2015. RN Guilfoyle said that in some circumstances it might have been useful to have this information. However, in MC's specific case RN Guilfoyle referred to the fact that the team had information regarding the calls made by TP on 22 May 2015 and that MC had presented well on 25 May 2015. RN Guilfoyle said that in hindsight it may have been a concern that there was inconsistency between what TP had reported and what MC himself was telling the team, but RN Guilfoyle said that she remained comforted by MC's positive presentation.

16.22 **Conclusion:** Given the uncertainty expressed by NUM Momirovic, it is evident that TP's report of her phone call with MC on the morning of 25 May 2015 was not conveyed to the RIT members. The absence of this information was another factor contributing to the inadequacy of the RIT assessment conducted on 25 May 2015. The effect of RN Guilfoyle's evidence is that this information, whilst inconsistent with what MC was reporting to the RIT members, would likely not have made a difference to the team's assessment given that MC had presented well.

16.23 However, best practice would suggest that the RIT should have been provided with all information relevant to their assessment of MC, particularly information that was so proximate to the time of their assessment. Indeed, the *NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff* (**the Framework**), which applied at the time of MC's death, "*provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of generalist and mental health services to guide the suicide risk assessment and management process*".[41] The Framework notes that "*collateral information, particularly from a family or support person, should always be sought as part of the re-assessment of suicide risk*".[42]

[40] Exhibit 1, page 816.
[41] Exhibit 1, page 1493.
[42] Exhibit 1, page 1518.

Communication with the MHSU

16.24 As already noted above, the evidence from Dr Phung established that it was usual practice within the MHSU for a RIT reviewing an inmate within the MHSU to refer back to that inmate's treating team prior to making a decision about whether to discharge the inmate from a RIT protocol. In MC's case it appears that this did not occur (accepting that Dr Phung acknowledged that it would have been helpful if he had made such a note in MC's progress notes) fundamentally because MC was being reviewed by a RIT outside of the MHSU.

16.25 The RIT Management Plan for MC upon his discharge from the RIT protocol contained instructions that MC was to be held in Darcy until a bed was available for him in the MHSU.[43] AS Bhalla was asked in evidence whether any contact was made with the MHSU given that it was the intention of the RIT to return MC there. AS Bhalla said that contact would only be made with the MHSU once the RIT had cleared MC and that it was the responsibility of the Justice Health nurse to make such contact. The purpose of this contact was only to determine if a bed was available for MC and which pod he would be sent to.

16.26 **Conclusion:** The usual practice within the MHSU was for safe cell conditions for an inmate under a RIT protocol to not be removed until a psychiatric review had occurred. This practice should have been followed in MC's case. It was not followed because MC's location in the Darcy unit created both a physical and therapeutical detachment between the RIT that assessed him and the MHSU treating team. As a component of a comprehensive suicide risk assessment the Framework provides that "*a consultant psychiatrist's opinion should be sought early, wherever possible, in the assessment and management of a person with suicide risk. This may be available as part of the team's routine case review meeting*".[44] The lack of reference by the RIT back to the MHSU treating team resulted in a further inadequacy concerning the RIT assessment conducted on 25 May 2015.

17. Was it appropriate to discharge MC from the RIT protocol on 25 May 2015?

17.1 It appears that MC's presentation on 25 May 2015 was an important factor in the decision made by the RIT members to discharge him from the RIT protocol. RN Guilfoyle said that MC presented as initially irate and angry, wanting to know why he was still being kept in his cell, but settled after a short time and appeared happy to answer questions from the team. RN Guilfoyle noted that MC was not distracted, made good eye contact, showed no perceptual disturbances and denied any thoughts of self-harm and hearing voices; RN Guilfoyle regarded all of this as positive signs. AS Bhalla explained that there was a discussion between the team members regarding MC's presentation with specific reference made to the notes made by Ms Foster on 23 May 2015.[45] AS Bhalla indicated that nothing adverse was detected in MC's presentation and noted that MC gave assurances that he was not going to harm himself.

17.2 However Dr Skinner was of the opinion that MC's presentation at the review was not a positive one. She explained that because MC wanted more freedom (to be taken off the RIT protocol, and allowed to smoke), his statements to the RIT were skewed towards positive answers so that he would be moved to a place which he found more preferable. Dr Skinner emphasised that Dr Phung had found MC's risk status to be changeable. Further, she also referred to the fact that MC

[43] Exhibit 1, page 343.
[44] Exhibit 1, page 1518.
[45] Exhibit 1, page 346.

had a change of medication so that it was possible the quetiapine he had been started on had had a calming effect so that any anxiety or fear that he had might have been reduced or eliminated; in this state he might give positive answers and appear well.

17.3 **Conclusion:** It appears that because the RIT on 25 May 2015 was not provided with the information it should have been, as already referred to above, there was an inaccurate assessment made of the apparent positivity of MC's presentation. Lack of awareness of the assessment of MC's changeability and the effects of his new medication regime contributed to this inaccuracy. As a result, it appears that insufficient consideration was given to follow-up measures to be put in place upon MC's discharge from the RIT protocol.

17.4 The RIT Management Plan that was completed upon MC's discharge from the RIT protocol noted that he was for normal cell placement, that he could have access to all of his normal possessions, and that focussed case management would be implemented. AS Bhalla said that he understood that once MC was deemed suitable for cell placement he would be subject to the normal routine of the pod where he would be housed. Specifically, this meant that MC would be locked in his cell at around 3:00pm where he would remain overnight until the following morning. The only interruption to this period would come in the form of the evening medication round at about 7:00pm. In this regard, AS Bhalla explained in evidence that the routine in Darcy was no different to the routine in the MHSU, in the sense that the door of a cell would only be opened in the event of an alarm raised by an inmate or the need to dispense medication to an inmate.

17.5 With this in mind, AS Bhalla was asked in general whether any consideration was given to the fact that there might be a continuing risk to MC. He said that once it was decided by the RIT that MC was at low risk, there was no reason to place him in any higher degree of restrictive environment. AS Bhalla was also asked whether any consideration was given to a step-down period or some degree of oversight. Again AS Bhalla indicated that this was unnecessary on the basis that once MC returned to the MHSU he would be subject to the more intensive management that was available in that area.

17.6 RN Guilfoyle was also asked whether she had any concerns that MC would go from a situation where he was under almost constant observation to a situation where he would be subject to almost no observation. She said that she had no such concern because it was her understanding that MC would be returned to the MHSU, as he had been admitted there, and that he could not be discharged from the Darcy unit. RN Guilfoyle agreed that instructions could have been given on discharge for MC to remain under some observation however she said that such instructions were not warranted given how well MC had presented at the time of review.

17.7 In her first report Dr Skinner opined that "*it was not appropriate to discharge [MC] from the RIT protocol…without a carefully prepared plan for follow-up*".[46] In particular, Dr Skinner noted that MC "*should have been transferred to a transitional cell arrangement with a 'step-down' before normal cell placement was considered*".[47]

17.8 Section 13.3 of the CSNSW Operations Procedures Manual (**OPM**), which was in force at the time of MC's death, defines step-down to be "*a gradual reduction in restricted access to amenities and specialist support within a structured RIT or 'focussed' case management plan*".[48] Focussed case

[46] Exhibit 1, tab 242.
[47] Ibid.
[48] Exhibit 1, page 554.

management is further defined in section 13.3 to mean "*a step-down procedure where specific requirements relating to shared accommodation and staff and allocation to monitor the inmate's mood and behaviour every two to three days is established for identified 'high risk' inmates with ongoing risk factors*".[49] Section 13.3.9 of the OPM deals with case management and progression planning for an inmate [redacted].[50]

17.9 AS Bhalla was asked specifically about his understanding of what focussed case management (**FCM**) meant. He explained that FCM refers to a situation where an inmate cannot be managed in a normal accommodation area and requires a high level of supervision. AS Bhalla was taken the definition of FCM in the OPM and asked if MC had a Case Officer allocated to perform the role as indicated. AS Bhalla said that he was unable to comment because his only interaction with MC occurred during the reviews conducted by the RIT and that the RIT expected MC to be returned to the MHSU on the same day as his discharge. However, AS Bhalla later explained that FCM in MC's case simply meant that MC was to be eventually returned to the MHSU where there would be increased and more intensive observations conducted.

17.10 Dr Skinner was asked in evidence what kind of step-down protocol she envisaged. She expressed concern that there had been no communication with the MHSU in general and no communication with the MHSU in particular about appropriate cell placement for MC in the interim period between his expected return to the MHSU. She also indicated that some consideration ought to have been given to limiting MC's access to bedding and to sharps. Further, Dr Skinner said that some kind of more frequent monitoring ought to have been provided for MC in order to give him some reassurance and reduce his anxiety, rather than simply leaving him alone.

17.11 AS Bhalla was asked whether he was familiar with the guidance provided in the OPM regarding the available step-down options for persons discharged from a RIT protocol. AS Bhalla said that there were no "*hard and fast*" guidelines and that adjustments were frequently made to ensure that inmates were managed in the best possible way.

17.12 Upon MC's discharge from the RIT a mandatory notification for offenders at risk of suicide and self-harm form was also completed by the RIT members. The form contains a section titled "*Monitoring (e.g. case officer to chat with inmate for (5) minutes each day)*" in which the words "*AS REQUIRED*" are pre-printed, and not completed by hand like other sections on the form.[51] AS Bhalla was asked about the words "AS REQUIRED" and indicated it was standard protocol for the phrase to be included on the form. He explained that the phrase simply meant that the monitoring requirements of the accommodation area where an inmate was returning to following discharge would be applied.

17.13 **Conclusion:** It appears that little, or no, specific consideration was given by the RIT to the need for some form of step-down protocol for MC following his discharge from the RIT protocol. It is accepted that the RIT expected that MC would be returned to the MHSU on the same day as his

[49] Ibid.
[50] Exhibit 1, page 564.
[51] Exhibit 1, page 341.

discharge and that the same procedures regarding cell lockdown would have been followed there as in the Darcy unit. Even allowing for this, due to MC's history of psychosis, his recent change in medication, and the fact that his risk level appeared to be highly changeable, some transitional arrangements were warranted.

17.14 It is acknowledged that the opinion expressed by Dr Skinner is this regard was offered with the benefit of hindsight. However, it appears that at least some greater consideration ought to have been given as to precisely what, if any, focused case management was to be provided for MC according to the terms of his RIT Management Plan. The evidence suggests that the only additional management to be provided for MC was his return to the MHSU, a more intensive environment than the one in which MC was housed in at the time of his discharge. This appears to be supported by the contents of the mandatory notification form and the words "AS REQUIRED" which suggest that no specific consideration was given to whether some additional monitoring of MC was needed. As noted by Dr Skinner this may have provided MC with some degree of reassurance. Of course, it is not possible to conclude, even if some level of additional monitoring had been provided for MC, whether this would have altered the eventual outcome in any way.

17.15 Having regard to the ways in which a psychiatric review prior to the removal of safe cell conditions and MC's discharge from the RIT protocol might have materially affected the RIT assessment process it is necessary to make the following recommendation.

17.16 **Recommendation:** I recommend to the Commissioner for Corrective Services NSW; the Chief Executive, Justice Health & Forensic Mental Health Network; and the Governor, Metropolitan Reception and Remand Centre, that consideration be given to collaboratively developing and implementing Local Operating Procedures for the Metropolitan Reception and Remand Centre. The procedures specifically relate to inmates from the Mental Health Screening Unit (**MHSU**) who have been placed on a Risk Intervention Team (**RIT**) Management Plan. The procedures should address the following: (a) Identify the circumstances in which a RIT should seek information from an inmate's Justice Health treating team in order to formulate a RIT Discharge Plan, particularly in situations where that inmate is placed in an assessment cell that is not within the MHSU; (b) How information relevant to an inmate's RIT Discharge Plan is to be shared between the inmate's Justice Health treating team and a RIT; and (c) The means by which any recommendation made by a psychiatrist that an inmate be subject to psychiatric review prior to discharge from a RIT Management Plan is to be communicated to a RIT.

18. Findings

18.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Jake Harris, Counsel Assisting, and his instructing solicitor, Ms Kathleen Hainsworth of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been invaluable. I would also like to thank them both for the sensitivity and empathy that they have shown throughout this matter. I also thank Detective Sergeant Damien Babb for his role in the police investigation and for compiling the initial brief of evidence

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

Identity
The person who died was MC.

Date of death
MC died on 25 May 2015.

Place of d
MC died at the Metropolitan Reception and Remand Centre, Silverwater NSW 2128.

Cause of death
The cause of MC's death was hanging.

Manner of death
MC died whilst in lawful custody as a consequence of actions taken by him with the intention of ending his own life.

19. Epilogue

19.1 MC's daughter, A, keeps a photo of her father in her room. She looks at the picture often and speaks to her father as if he is with her. A also often says that her daddy is in her heart and is flying high in the sky. In words spoken by GG at the conclusion of the inquest, MC is always watching over his children, M, K, and A.

19.2 On behalf of the Coroner's Court, and the counsel assisting team, I extend my deepest sympathies and offer my respectful condolences to TP; GG; A, M, and K; MC's siblings, D, A and A; and the rest of MC's family for their most painful and tragic loss.

19.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
31 August 2018
NSW State Coroner's Court, Glebe