



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of Jason Muehlfenzl

Hearing dates: 8 May 2018

Date of findings: 8 May 2018

Place of findings: NSW State Coroner's Court, Glebe

Findings of: Magistrate Derek Lee, Deputy State Coroner

Catchwords: CORONIAL LAW – death in custody, self-inflicted death, Bathurst Correctional Complex

File numbers: 2016/231300

Representation: Ms T Xanthos, Coronial Advocate assisting the Coroner

Ms J De Castro Lopo for the Commissioner for Corrective Services
New South Wales

Ms S Li for Justice Health & Forensic Mental Health Network

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order: I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009*, the following material is not to be published:

1. The address contained in Exhibit 1, tab 8, page 3.
2. The phone numbers contained in Exhibit 1, tab 27.

Findings: I find that Jason Muehlfenzl died on 31 July 2016 or 1 August 2016 whilst in lawful custody at Bathurst Correctional Complex, Bathurst NSW 2795 where he was serving a custodial sentence. The cause of Mr Muehlfenzl's death was neck compression due to hanging. Mr Muehlfenzl died as a consequence of actions taken by him with the intention of ending life.

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Introduction

1. Jason Muehlfnzl was last seen alive on the evening of 31 July 2016 whilst he was being held in lawful custody at Bathurst Correctional Complex where he was serving a custodial sentence. Tragically, the following morning Mr Muehlfnzl was found in his cell, deceased, after having apparently taken his own life.

Why was an inquest held?

2. When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.
3. 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* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

Jason's life

4. Before going on to set out the findings from the inquest it is appropriate at this point to recognise, and say a few brief words about, Jason's life.¹ Much of the evidence that is gathered in a coronial investigation relates to the final period of a person's life. That final period is often measured in hours, minutes and, sometimes, seconds. That final period is often intensely scrutinised during an inquest. These circumstances rarely allow for much consideration to be given to the (usually) years of life that preceded a person's death, who that person was, and how their death has impacted their family and loved ones. Therefore it is important to recognise the life of that person in some small, but hopefully meaningful, way.
5. Jason was born in 1970 in Sydney and grew up in the suburb of Daceyville. Jason was one of three children to Max and Betty Muehlfnzl, with the others being an older brother, Karl, and an older sister, Kim. After spending some years in Daceyville, Jason and his mother later moved to Belfield and then Hammondville. In his youth Jason enjoyed playing football and motorbike riding. Jason later found a job as a delivery driver, and also met his former partner, Vicky Anderson. They moved to Condell Park and had two children together: Kirstie and Corey.
6. Unfortunately, from the age of about 20, Jason began having trouble with the law and was in and out of custody over the course of a number of years. Jason also spent some time in custody in

¹ I will refer to Jason by his first name in these findings. No disrespect is, of course, intended to Jason, or the members of his family.

Queensland. When he was released in 2013 he went to see his mother in Hammondville who was at that time in poor health. Sadly, Jason's mother later passed away in July 2014. Jason was particularly close to his mother and her death profoundly affected him.

7. Jason received an inheritance from the sale of his mother's house and later moved to the Central Coast with his new partner at the time, Elizabeth Sheppard. Jason's brother, Karl, and Ms Sheppard's son, Corban, also accompanied Jason and Ms Sheppard in their move. Regrettably Jason and Karl later had a disagreement with resulted in Karl leaving the Central Coast area. However, Jason and Ms Sheppard remained in the area and Jason developed a close relationship with Corbin.

Custodial history

8. In 2011 Jason was convicted of an offence in Queensland that resulted in him being sentenced to five years imprisonment expiring on 15 November 2016, with a non-parole period that expired on 17 July 2013. Jason was released on parole on that date with one of the conditions of his parole that he be of good behaviour. On 16 February 2016 Jason's parole was revoked by virtue of him allegedly breaching his parole. As a result, on 26 February 2016 a warrant was issued for Jason's arrest.
9. Jason was later apprehended and refused bail on 10 March 2016. He was taken into custody at Cessnock Correctional Centre (**Cessnock**) the following day on a revocation of parole warrant. On 19 April 2016 Jason was convicted and sentenced to eight months imprisonment at Newcastle Local Court (in relation to new offences that had been committed on 7 March 2016) with the sentence due to expire on 9 December 2016. On 3 June 2016 the State Parole Authority determined that, in view of Jason's conviction that his parole was to remain revoked.
10. At Cessnock Jason was initially placed in a two-out cell on 11 March 2016 after it was noted on a Health Problem Notification Form that he presented with low mood, anxiety and agitation.² On 23 March 2016 Jason was reviewed and assessed as being suitable for normal cell placement as no acute concerns were noted.
11. On 23 April 2016 Jason was transferred to the Metropolitan Special Programs Centre at Long Bay Correctional Centre. Upon review by a nurse at reception Jason guaranteed his own safety. On 20 June 2016 nursing staff noted that Jason's mental health was stable.
12. On 19 July 2016 Jason was reviewed by a mental health nurse. Jason reported being content with his medication (quetiapine and mirtazapine) and was positive when speaking about his plans for the future upon release from custody. Jason reported that he had not experienced any psychotic symptoms and that he had no thoughts of suicide or self-harm.
13. On 21 July 2016 Jason was transferred to Bathurst Correctional Complex (**Bathurst**). On arrival Jason took part in a routine Reception Screening Assessment.³ During this assessment Jason reported that he had previously been diagnosed with schizophrenia and that he had a history of daily cannabis use, infrequent methamphetamine use, and alcohol abuse. Jason also reported that he had experienced suicidal ideation some 18 months earlier following the death of his mother, but denied any current suicidal thought or intent.

² Exhibit 1, tab 31.

³ Ibid.

Events leading up to 31 July 2016

14. Barry Nikolovski, another person in lawful custody, met Jason around 21 July 2016 after he was transferred to Bathurst from another correctional centre. Jason and Mr Nikolovski were initially housed together for several days. Jason was later temporarily moved to a different cell but upon his transfer to a different wing at Bathurst he was placed in the same cell as Mr Nikolovski again.
15. On or about 29 July 2016 Jason asked Mr Nikolovski to help him plait together some torn bed sheets. When Mr Nikolovski asked what he was doing, Jason said that he was making a clothesline. At some stage Mr Nikolovski saw Jason attempt to thread the makeshift clothesline of plaited sheets through a vent above the cell door. Mr Nikolovski told Jason that the correctional officers were likely to tear it down and so Jason removed it himself. At around the same time Jason told Mr Nikolovski that he had had an argument with Ms Sheppard over the phone and that this had angered Ms Sheppard.
16. Mr Nikolovski recalls that Jason made three or four “clotheslines” using a loose razor blade to cut the sheets and then plait them together. Each line was about 1 to 1.5 metres in length. Mr Nikolovski said that he thought nothing of Jason’s activities and said that he never suspected that Jason was going to harm himself.⁴

What happened on 31 July 2016?

17. Jason called Ms Sheppard⁵ at 3:40pm on 31 July 2016. After speaking for only a short time Ms Sheppard told Jason that she could not “*do this anymore*”. Jason asked Ms Sheppard if she had “*found someone else*” to which Ms Sheppard replied, “*Maybe*” and “*I don’t know*”. Jason said, “*Well I will neck myself if I have to lose you again, I can’t do it babe. I love you too much*”. Jason again asked Ms Sheppard whether she had met someone else. Ms Sheppard was initially equivocal in her response but later denied that she had. Ms Sheppard went on to tell Jason that she had had enough and ended the call.
18. Jason attempted to call Ms Sheppard again at 4:02pm but the call was unanswered. Jason left a voicemail message in which he said, “*Tell Corbin I love him forever. I love you forever, and I’ll join my mum tonight. I love you, bye. I promise, Correctives will ring you tomorrow*”.
19. Jason called Ms Sheppard a third time at 4:23pm. Ms Sheppard answered the call and there was a brief argument about her having ended the first call. At one point Jason said, “*I’m going to neck*”. There was some further discussion about Ms Sheppard ending the relationship with Jason again asking if she was seeing someone else before the call ended.
20. Following the phone calls Jason was returned to his cell. During the evening Jason and Mr Nikolovski spent some time watching TV and at some stage Jason wrote a letter and asked Mr Nikolovski to remind him in the morning to post it.
21. Mr Nikolovski went to sleep at about 10:30pm. At the time Jason was in his bunk above Mr Nikolovski, listening to the radio. At one stage during the night Mr Nikolovski got up to turn off the radio. At another time, Mr Nikolovski got up to use the toilet. Mr Nikolovski did not notice anything amiss on either occasion.

⁴ Exhibit 1, tab 25 at [8].

⁵ Exhibit 1, tab 28.

What happened on 1 August 2016?

22. Mr Nikolovski woke up the following morning, got out of bed and tripped over a milk crate that had been left in the middle of the floor. Mr Nikolovski also heard that the radio had been turned up to a loud volume. As he called out to Jason to ask why the milk crate was in the middle of the floor, he noticed that Jason was suspended in the doorway from the plaited sheet that had been tied around his neck.
23. At the same time a Corrective Services NSW (CSNSW) officer who was conducting a morning check of the cells opened the door to the cell where Jason and Mr Nikolovski were housed and saw Jason. Another CSNSW officer was alerted and together they cut the sheet in order to release Jason and assist him to the ground. Jason was found to have no pulse and no signs of life. CPR was commenced and a call was made for emergency services to attend. Paramedics arrived on scene at about 6:23am and continued to perform CPR with no signs of life established. Jason was later pronounced life extinct at 6:30am.
24. During a subsequent search of Jason's cell four letters were located. Two of the letters were addressed to Ms Sheppard; one to Jason's brother, Karl; and one to a police officer in Victoria which contained a number of allegations. In his letters to Ms Sheppard, Jason wrote, "*I can't live without you, I miss my mum so bad and you, Corban so bad I'm not lieing [sic] I want to knock myself*". In his letter to his brother, Jason wrote, "*I have thought about suicide a couple of times but you only get one life so as bad as it has got I'm trying my best*".
25. A further letter⁶ was also located in the pocket of Jason's pants. The letter was dated 1 August 2016, addressed to Ms Sheppard, and bore a heading which read, "*My last words*". In the letter Jason expressed his love for Ms Sheppard and left instructions for the disbursement of his property and where he wished to be buried.

What was the cause of Jason's death?

26. Jason was later taken to the Department of Forensic Medicine at Newcastle. Dr Jane Vuletic, senior staff specialist in forensic pathology, performed the post-mortem examination on 3 August 2016 and later prepared an autopsy report dated 30 August 2016. Dr Vuletic noted that Jason had sustained fractures of the hyoid bone and thyroid cartilages, and abrasions on the neck, which were consistent the application of pressure on the neck with a ligature. Dr Vuletic found no other bodily markings to indicate the involvement of another person in Jason's death and ultimately concluded that the cause of death was hanging.

What was the manner of Jason's death?

27. 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. I have had regard to Jason's history of previous suicidal ideation, the lasting adverse effect that the passing of Jason's mother had on Jason's mental well-being, Jason's suicidal ideation which he voiced to Ms Sheppard during the phone calls on 31 July 2016, Jason's preparatory actions in constructing a ligature from plaited bed sheets several days prior to his death, and the content of the letter dated 1 August 2016 which was found in Jason's pocket.

⁶ Exhibit 1, tab 27.

28. Taking all of these matters into account, together with the circumstances in which Jason's was found, I conclude that the evidence is sufficiently clear, cogent and exact⁷ to allow a finding to be made that Jason died as a consequence of actions taken by him with the intention of ending his life.

Was Jason's care appropriately and adequately managed whilst in custody?

29. Jason's death raises two questions concerning his care whilst in custody:

(a) Firstly, was Jason housed in an appropriate cell?

(b) Secondly, was there any way to predict Jason's actions during the evening of 31 July 2016 and therefore prevent them from occurring?

30. In relation to the first question the evidence establishes that Jason was housed in a section of Bathurst known as X-Wing. This wing houses minimum security inmates who are deemed to be not at risk of suicide or self-harm.⁸ As a result of this classification no structural or physical modifications had been made to the cells in X-Wing to, for example, remove possible hanging points.⁹ The evidence establishes that no cell searches were conducted from the time that Jason arrived in X-Wing on 26 July 2016.¹⁰ Therefore, there was no opportunity for any CSNSW officer to discover the plaited sheet that Jason had been making from about 29 July 2016.

31. The evidence described above raises a further question: namely, whether it was appropriate for Jason to be housed in X-Wing. The records from both CSNSW and Justice Health & Forensic Mental Health Network (**Justice Health**) indicate that between 10 March 2016 and 31 July 2016 there was no evidence to indicate that Jason posed a risk to himself. During his initial reception screening assessment upon entering custody and during subsequent reviews conducted by Justice Health staff, Jason denied any thoughts of self-harm or suicidal intent. On 19 July 2016, during the most recent mental health assessment conducted prior to his death, Jason again denied any thoughts of suicide or self-harm and instead expressed positive plans for the future.¹¹

32. **Conclusion:** Having regard to the totality of the records available there is no evidence to indicate that, in the period between 10 March 2016 to 31 July 2016, Jason was at risk of suicide or self-harm. Accordingly, it was appropriate for Jason to have been housed in the minimum security X-Wing upon his transfer to Bathurst.

33. In relation to the second question it is evident that Jason had expressed suicidal ideation to Ms Sheppard during the series of phone calls on 31 July 2016. However, although these calls were recorded (in accordance with standard procedures at a correctional centre) they were not monitored by any CSNSW staff at the time the calls were taking place. The content of the conversations between Jason and Ms Sheppard only became known during the police investigation after Jason's death. Importantly, this meant that what was said by Jason during these phone calls was never brought to the attention of any CSNSW or Justice Health staff before Jason's death.

⁷ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

⁸ Exhibit 1, tab 32 at [10].

⁹ *Ibid* at [16].

¹⁰ *Ibid* at [12].

¹¹ Exhibit 1, tab 31.

34. The evidence gathered during the coronial investigation established that as at 2017 there were over 14,000 persons detained in NSW correctional centres.¹² It would therefore be impossible to monitor every phone call of every person held in custody. More specifically, the evidence established that monitoring of specific calls usually only occurs when CSNSW, or an investigative agency, possesses information that suggests that unauthorised or illegal activity is being discussed during a call.¹³ There was no basis for the calls between Jason and Ms Sheppard on 31 July 2016 to be monitored.
35. Mr Nikolovski was aware that Jason had been plaiting the sheets together to form what Jason explained would be a “clothesline”. Mr Nikolovski was also aware that Jason had been involved in an argument with Ms Sheppard around the time he began plaiting the sheets. In hindsight, it is perhaps easy to draw a logical connection between what was known to Mr Nikolovski around this time and Jason’s subsequent actions. However, reaching such an inference without the benefit of hindsight is a more difficult task.

36. **Conclusion:** Ultimately it is unnecessary to speculate about whether the drawing of such an inference by Mr Nikolovski was possible. The fact remains that by 31 July 2016 no information had been communicated to CSNSW or Justice Health staff by any third party which raised the possibility that Jason was at risk of suicide or self-harm. I therefore conclude that there was no basis upon which any CSNSW or Justice Health staff could have predicted Jason’s actions and taken possible preventative measures. I also therefore conclude that the care provided to Jason whilst in custody, in the period from 10 March 2016 to 1 August 2016, was adequate and appropriate. There is no evidence to suggest that any inaction by CSNSW or Justice Health or staff contributed to Jason’s death.

Findings

37. Before turning to the findings that I am required to make, I would like to thank Ms Tina Xanthos, Coronial Advocate, for her assistance with the preparation and conduct of this inquest. I would also like to thank Detective Sergeant Joseph Coorey, the officer-in-charge of the police investigation.
38. The findings that I make under section 81(1) of the Act are as follows:

Identity

The person who died was Jason Muehlfnzl.

Date of death

Jason died on 31 July 2016 or 1 August 2016.

Place of death

Jason died whilst in lawful custody at Bathurst Correctional Complex, Bathurst NSW 2795.

Cause of death

The cause of Jason’s death was neck compression due to hanging.

¹² Exhibit 1, tab 4 at [52].

¹³ Ibid.

Manner of death

Jason died as a consequence of actions taken by him with the intention of ending life.

Epilogue

39. As demonstrated by the attendance of several members of Jason's family during the inquest, Jason is greatly missed. On behalf of the NSW Coroners Court I extend my sincere and respectful condolences to Jason's family for their tragic and painful loss.

40. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
8 May 2018
NSW State Coroner's Court, Glebe