CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Into the death of "RN"
Hearing dates:	1-2, 4-5 July 2019
Date of findings:	25 October 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E.Truscott
Catchwords:	Coronial Law-Cause and manner of death- death in custody-basic English-interpreter- Amber Laurel Corrections Inmate Identification and Observation- Parklea Corrections Centre Prisoner Reception Screening- Corrective Services Inmate Screening Questionnaire-Justice Health Risk Screening Assessment- telephone call to family as protective factor
File number:	2016/107266
Representation:	Counsel Assisting : Mr P Aitken instructed by Mr P Armstrong of Crown Solicitors Office Family of deceased: Ms Cooper of Legal Aid Commission NSW Department of Corrective Services NSW: Mr Tumeth and Ms J Castro de Lopo of Office of General Counsel, Department of Justice NSW Justice Health & Forensic Mental Health Network : Mr B Bradley instructed by Ms S Idowu of Makinson D'Apice Lawyers GEO Group Australia Pty Ltd: Ms T Berberian instructed by Ms M Carthew of Sparke Helmore MTC Broadspectrum: Mr J Harris instructed by Ms T Vivoda of MTC Broadspectrum Ms S. Howlett: Ms P Robertson of NSW Nurses Association

	Mr A. Russell: Mr R Reitano instructed by Ms B Sambolic of McNally Jones Staff Lawyers St Vincent's Health Network Sydney (St Vincent's Correctional Health): Ms Z Hamilton
Findings:	**Identity** The person who died is known as "RN" **Date of Death** RN died on 7 April 2016 **Place of Death** RN died in the bathroom of his cell at Parklea Correctional Centre, Quakers Hill NSW **Cause of death** RN died as a result of asphyxiation by ligature **Manner of death** RN's death was intentional and self-inflicted in circumstances where he was a recent remand prisoner at Parklea Correctional Centre.
Recommendations:	**<u>To the Commissioner of Corrective Services NSW</u>** **I recommend that consideration be given to developing a policy requirement for inmates, who are detained in custody and housed at Amber Laurel Correctional Centre prior to movement to a reception centre, be provided with a personal telephone call to a nominated family member preferably within 24 hours but certainly no later than 48 hours.**
Non-Publication Orders:	1. Section 75(2)(b) - Order previously made that deceased's name is not to be published and he is to be known as RN is continued and amended to middle names of family members (to prevent identification of deceased and any family members). 2. Section 74(1)(b) - "NPO" previously made in relation to Julie Ellis statement is to continue with additional statements

	of Ms Ellis dated 26/06/2019 included in the order and all documents located in Volume 5 - Tab 142A. 3. Section 74(1) (b) - PAS Waiting List Priority (Justice Health and Forensic Mental Health Network) in Volume 2 - Tab 82. 4. Section 74(2) (b) - GEO Group Volume 2 - Tabs 67-78; Volume 3 - Tab 102; Volume 4 - Tab 136. 5. Section 74(2) (b) - MTC Broadspectrum Volume 5 - Tab 146, Mr Baker's statement and policy documents 4.0.8, 5.0.2 and 5.1.4 6. Section 74(2)(b) - The identity of a person known as “WW” referred to at: Tab 23, Pg.1 [ii] & Pg.8 Tab 28, Pg.1 [ii] Tab 30, Pg.3 [ix] & Pg. 4 [ix] Tab 103, Pg.2 [6] & [7], Pg.6 [18], Pg.18 [6] and Pg.22 [31] Tab 106, Pg. 1 Tab 107, Pgs. 1,2 & 3 Tab 119, Pg. 1

IN THE CORONERS COURT
LIDCOMBE
NSW

Sections 23 and 81 *Coroners Act 2009*

REASONS FOR DECISION

Introduction

1. This is a required inquest pursuant to s23 (a) of the *Coroners Act 2009* ("the Act") as RN died whilst he was a prisoner on remand at Parklea Correctional Centre ("PCC"). RN was 58 years old, the loved father of daughter S and son M, brother of Sm and husband of NK[1].

2. On 31 March 2016, a week prior to RN's death he was arrested and charged with a serious assault upon his wife in their family home. It was the first time RN had ever been arrested or had ever been in custody in Australia. At about 9 pm he was taken to Green Valley Police Station (in Liverpool) and the services of a Khmer speaking interpreter were obtained at his request. With the assistance of the interpreter RN participated in a police interview. He was then charged and was refused bail. A Provisional Apprehended Violence Order was served on RN which prohibited him having contact with his wife who by that time was hospitalised.

3. At about 4 a.m. on 1 April, RN was transferred from the Green Valley police station cells to Amber Laurel Correctional Centre which is operated by Corrective Services NSW ("CSNSW") where he was received by Mr Russell who was a

[1] As RN died as a result of suicide, and pursuant to s. 75 of the Act, his name and the names of his family members have been anonymised to ensure that there is no publication of any identifying details.

CSNSW staff member in the Court Escort Security Unit ("CESU"). RN was due to appear by Audio Visual Link ("AVL") in the Liverpool Local Court later that day.

4. Mr Russell was tasked with completing a paper form titled "Inmate Identification and Observation"("IIO"). Information from that form is entered into the CSNSW electronic database which would generate an identification number for RN and all the details on the form would be created and assigned. Mr Russell ticked the box that said RN required an interpreter and wrote that the language was Cantonese. After Mr Russell had processed RN, RN was placed in a cell and later retrieved to attend court by AVL.

5. Before his expected court appearance RN was interviewed via AVL by Mr Anderson, a solicitor on the legal aid duty roster. RN's sister Sm attended the interview and acted as interpreter. RN's case was mentioned in court without RN appearing in court on the AVL. His case was adjourned to 15 April 2016 without any application for bail being made so it was formally refused. The court was asked to order a Khmer interpreter for 15 April. Apart from seeing his sister on AVL when Mr Anderson spoke with him, RN had no further contact with his family.

6. RN remained at Amber Laurel. Sm attended but was unable to visit him and left some clothes for RN. On 4 April, RN was transferred to PCC (then under the operation of GEO Australia Pty Ltd ("GEO")) arriving there at about 12.45 pm.

7. From 9-30 – 10 pm RN underwent reception screening at PCC which involved RN speaking with endorsed enrolled nurse Ms Howlett employed by Justice Health & Forensic Mental Health Network ("JH&FMHN"). When Ms Howlett interviewed RN she had access to the IIO. According to Ms Howlett she asked RN if he wanted her to telephone an interpreter and he declined. She completed two electronic forms called a "Reception Screening Assessment" ("RSA") and a "Health Problem Notification Form ("HPNF") which stated RN was *a "first time prisoner"* and that he spoke *"basic English"*. She also made an appointment for him to see the medical clinic on 5 April on the "Patient Administration System" ("PAS"). An electronic document called a Drug & Alcohol and Mental Health Summary is generated for the CSNSW Case Management File ("CMF"). The

RSA remains a confidential JH&FMHN document. After completing the process with Ms Howlett RN was placed in a cell with 2 other inmates. The time was shortly before midnight – it having taken nearly 12 hours from disembarking the prison truck to entering his cell.

8. On 5 April 2016, an electronic form called "Intake Screening Questionnaire" ("ISQ") was created in anticipation that RN would be screened by CSNSW. However, that did not occur on that day as RN was required to appear in Liverpool Local Court for the first mention of the Application for Apprehended Violence Order which the police had not linked to the criminal charges. RN did not leave PCC to go to court as he was listed to appear by AVL.

9. It is unclear if RN did in fact appear in court (via AVL) or whether his legal aid solicitor mentioned the matter on his behalf and adjourned the matter to 15 April 2016 to accompany the criminal charges listed on that date. In any event, RN was not screened for the purposes of the ISQ until 6 April.

10. By this time RN had spent 3 nights at Amber Laurel and 2 nights at Parklea without having telephoned any family member, having only seen and spoken with his sister Sm on AVL when he was briefly interviewed by Mr Anderson 5 days earlier.

11. CSCNSW Services and Operational assistant Mr Pauu completed the ISQ. He did not use the services of an interpreter. At the time a statement was not obtained from Mr Pauu and since that time, Mr Pauu has died. Mr Bradley was Mr Pauu's supervisor and assessor of the ISQ. He gave evidence about the form.

12. On 6 April RN was moved from the previous cell to another and at about 1 pm on 7 April he was moved again to another cell which housed 1 other prisoner. This was either shortly before or after his interview with Mr Pauu who says he completed the ISQ at about 1.10 pm. RN then attended a legal visit with a solicitor Mr Munzenreider, who had been retained by RN's sister Sm. Mr Munzenreider attended RN for a short time commencing his visit at 1.50 pm and left the prison at about 2.30 pm. Mr Munzenreider said that he was able to converse with RN without the use of an interpreter.

13. At 3 pm RN was returned to his cell and he and his cellmate were provided dinner and locked in for the night with the anticipation that the cell would be unlocked at 8 am the following morning. After eating dinner, RN's cellmate had a shower and he said that he saw RN writing something. The cellmate went to sleep and awoke at about 9 pm to go to the bathroom. When he entered the bathroom he saw RN hanging from a sock attached to the shower rail.

14. The cellmate pressed a call button in the cell which, by a system called "Stenofon", alerts the Parklea control room. Every cell has such a button and though it is designed to be used in the event of medical emergencies only, it is in fact used by prisoners for whatever reason they choose. At that time the PCC Control room was staffed by one person during the night. That staff member had the onerous task of monitoring the entire prison by numerous CCTV screens and answering and logging of each and every Stenofon call.

15. Ms McFarland was on duty that night. She answered RN's cellmate's call about 14 minutes after the button was pressed. As soon as she learned the reason for the call Ms McFarland made an urgent request for officers to attend RN's cell. RN had been deceased for some time as his body was cold. Inside the cell, officers found a letter that RN had written to his family dated 6 April and 7 April. It is clear from that correspondence that RN was considering ending his life on 6 April and determined to do so after his legal visit on 7 April.

Issues in the Inquest

16. Of particular focus in this inquest is the process of the reception screening to examine whether RN's well-being was properly assessed having regard to the fact that he was a middle aged man with basic English skills and it was his first time in custody in Australia. The nature of the questions asked on the pro forma screening forms and how they were or were not completed and the decision of each screening officer to not request the assistance of an interpreter has also been scrutinised.

17. The second issue arising from RN's death was the response time taken to answer the call made to the control room. At the inquest GEO made numerous

admissions in this regard so it is not controversial. As a result of their own investigation it was identified that the call remained unanswered due to only one staff member being allocated duties in the control room which oversees the entire prison. Such staff allocation was inadequate and at the conclusion of that investigation the inquest learned that the control room has since been staffed by two persons, one of whom has sole responsibility for dealing with Stenofon calls so that they are answered and dealt with in a timely fashion.

18. The third issue identified initially by investigators was the extent to which the PCC cell had been scrutinised to ensure that there were no obviously accessible hanging points. Evidence was subsequently received which shows that this issue has been responded to and is part of an ongoing response. The hanging point used in RN's death has been removed.

19. At the time of RN's death PCC was operated by GEO and the health care provider was JH&FMHN. Since 1 April 2019, PCC has been operated by MTC Broadspectrum Australia ("Broadspectrum") and health care is provided by St Vincent's Health Network Sydney (St Vincent's Correctional Health) ("St Vincent's"). The Inquest also received evidence relating to the extent to which the procedures and policies of CSNSW and JH&FMHN, respectively, are followed and implemented in the Centre.

20. However, the inquest is principally concerned with the manner of RN's death consistent with the Coroner's obligation to do so under s. 81 of the Act; the approximate time, the cause and the place is not in issue.

RN's Background

21. RN was born in Cambodia on 9 September 1957. He had 11 brothers and sisters, 5 of whom died during the time of the Khmer Rouge terror regime.

22. One brother and four sisters live in Australia now. RN did not move to Australia until 1994, when he would have been in his mid to late thirties. RN and his wife NK met in Cambodia when he was 32 and they had both children in Cambodia before immigrating to Sydney.

23. In Sydney both parents worked hard and bought a house together in West Hoxton. RN apparently had a long-term gambling issue which caused friction from time to time in the marriage. In about 2008/9 RN was diagnosed with high blood pressure and high cholesterol and began taking medication. He was otherwise healthy.

24. In 2015, NK began to work at Curtis Island in Qld, which involved being away from home for 4 weeks out of every 5. That same year RN went to Perth for about six weeks and when he returned he and his wife apparently began to have marital issues.

25. RN thought that his wife was going to leave him which apparently led to the matter for which he was arrested, charged, bail refused and remanded in custody. The letters which RN wrote whilst in prison prior to his death eloquently speak of his regret and his deep love for his wife and children.

The Brief of Evidence and Witnesses

26. Written statements were obtained during the investigation and are compiled into a brief of evidence together with other documents such as police, health and correctional centre records. The brief of evidence was tendered through the Officer in Charge, Detective Sergeant Joseph Coorey. Some witnesses were called to give evidence in person so that parties who have a relevant interest in those matters had the opportunity to test the evidence in relation to those issues.

27. The witnesses called included those who completed the forms at Amber Laurel and Parklea correctional centres as well as Ms McFarlane who was the control room operator on the night RN died. Representatives from all stakeholders - CSNSW, GEO Group Australia, JH&FMHN, St Vincent's and Broadspectrum – were called and gave evidence about the policy and monitoring of compliance in relation to the provision of screening services. I also heard evidence from Associate Professor Dean in relation to the screening tool which was used when RN was in custody and the new screening tool which is being implemented by CSNSW so that a prisoner's mental health can be better assessed.

The Events Leading up to RN's Death

RN in custody at the Green Valley Police Station

28. When RN was arrested at his home he was cautioned and taken to the Green Valley Police Station in Liverpool. Custody Management Records were sent with RN to the Amber Laurel facility to inform CSNSW. Those records show that RN was spoken to by Snr Constable Dudley, the custody manager. RN requested a Khmer interpreter to attend the station and interpret for RN. The interpreter had arrived by 10.45pm at which time the caution and summary of his custodial rights was given and translated to RN.

29. RN then requested to speak by telephone with his sister "Sm". At about 11 pm a telephone message was left with Sm's daughter for Sm to contact the police station. Sm called at about 11.15 pm and left her mobile number on which she could be contacted. However, there is no record indicating that Sm's mobile phone number was written down or kept to give to RN so he, the Officer in Charge or the Duty Manager could ring her.

30. Between about 11.30 pm and 00.20 am, RN participated in an interview with the police assisted by the interpreter. He was charged at 1.10 am.

31. The custody management records indicate that prior to the arrival of the Khmer interpreter RN was spoken to by Snr Constable Dudley who recorded in the Custody Management Report that RN did not make any threats of self-harm, he did not appear severely agitated or irrational, and it was his first time in custody.

32. Officer Dudley made comments about a brief assessment of RN that he *"appears fine and well, nil complaints of health"*, in relation to visual assessment he has commented *"nil issues raised. Conversant"*. In relation to a vulnerability assessment he noted that RN was from a non-English speaking background and that he was an Australian citizen/resident.

33. Details of RN's medical conditions were recorded indicating that RN takes medication for *"High Blood pressure & Cholesterol tablets every morning"* and that it was his first time in custody. A comment was written as follows: *"nil issues. Conversant, on speaking with a copy of Part 9 Summary*[2] *he has*

[2] Part 9 *Law Enforcement and Protection (Powers and Responsibility) Act 2002*

requested a Khmer interpreter". It was at that point, that an interpreter was called to come in to the station.

34. Sm gave evidence that after she spoke with the police at the station she made inquiries about where RN could stay if granted bail and by the time she telephoned the police back they told her RN had been transferred to Amber Laurel and that he would appear in Liverpool Local Court that day.

RN's reception at Amber Laurel Correctional Centre and the Performance of an Inadequate Screening Process

35. RN arrived at Amber Laurel Correctional Centre sometime in the early hours of the morning on 1 April. The police Custody Management Records were also sent with him. Sm's phone number was not recorded on any of the documents sent from the police station.

36. Mr Adrian Russell was the Court Services Corrections Officer who was tasked with receiving and processing RN. This task included completing a 'New Inmate Lodgement and Special Instruction Sheet' and an 'Inmate Identification and Observation Form' ("IIO").

37. The Court Services reception and screening is the first step in a prisoner reception screening process for all incoming prisoners in NSW. The IIO is either filled out by Court Services corrections staff at any NSW Court or at two of the centres in Sydney - one is the Sydney Police Centre and the other is Amber Laurel. Those cells are operated by CSNSW.

38. Mr Russell gave evidence that upon RN's arrival at Amber Laurel he would have firstly been strip searched by two officers, provided clothing and then brought before Mr Russell in company of those two officers. Mr Russell would then start to fill out the IIO which required him to make observations of RN and obtain information from him. The time Mr Russell recorded on the IIO was 04.45 am.

39. The form is a document which founds much of a prisoner's file. It is particularly important for a prisoner who has never been in custody before. The IIO is a six page document with four sections:

40. **Section 1 Personal Description** form which includes Emergency Contact Person, Next of Kin, whether an interpreter is required, country of birth, height weight build and hair eye facial hair colour, whether the prisoner is Aboriginal or Torres Strait Islander origin, citizenship status, language spoken at home, religion, address, identifying marks, details of any children, criminal history, whether there are any other current matters including an AVO and whether this is the first incarceration or any concerns about being in a correctional centre and whether the inmate has been informed about the right of appeal for bail to the Supreme Court and finally a privacy provision requiring the inmate to acknowledge receipt of notice and that his private information could be disclosed.

41. Mr Russell was taken through the 6 page IIO document and the single page document "New Inmate Lodgement & Special Instruction Sheet". He confirmed that the IIO only contained his writing in one place and that he had ticked that RN required an interpreter and the language was Cantonese and that he had ticked the box indicating that the police Case Management Records (from the police station) had been read.

42. **Section 2 Health History** which includes questions about **suicidality** as well as drugs, alcohol, methadone, diet and physical disability.

43. Mr Russell gave evidence that he did not ask RN any questions. The IIO has a written answer to the question "**Any other general medical conditions",** being "High blood pressure & cholesterol". When a person is taken from the police cells to the Amber Laurel Centre a police document called the "Case Management travels with the inmate. It would appear that that information has been placed on the IIO as a result of an Officer (other than Mr Russell) reading that document.

44. **Section 3** relates to the Officer's **Visual Assessment- Self harm** with a list of nine questions requiring a yes or no box to be ticked as well as another comment box. At the end of the Visual Assessment section the question is asked: "After reading the Police CMR and completing this interview and visual assessment, in your opinion, is the offender at risk of self-harm or suicide". Mr Russell ticked "No". He said he didn't fill out the answers to the previous nine boxes because

he didn't think it was required as the answers were all "No" and that on his visual assessment RN "mustn't have seemed upset".

45. **Section 4** relates to **Supporting information** and again has nine "yes" or "no" boxes all of which Mr Russell left blank including as to whether there were any alerts on the CSNSW Offender Inmate Management System ("OIMS"). However before signing the confirmation on the form, Mr Russell did tick two boxes being that Court Staff had been informed of **'at risk factors**' from CMR or IIO, and that the information had been entered on OIMS (including alerts). It is noted that there were none.

46. Mr Russell then completed the New Inmate Lodgement and Special Instruction Sheet ("NILSIS") whereby he identified that RN required an interpreter and the language was Cantonese. Mr Russell was unable to identify who had filled out the information in relation to items he hadn't written but he did answer "yes" that the IIO had been completed and he indicated on the form that he had informed the Transporting Officer of "At Risk" and other relevant alerts (of which there were none).

47. Mr Russell joined CSNSW in 2015, and, after graduating from a nine week training programme at a facility known as "Brush Farm", his first employment position was as a "Court Officer" at Amber Laurel. He said he occupied that position for 12 months. Mr Russell gave evidence that at no time did he receive any training from CSNSW about how to approach or complete the IIO form. Since Mr Russell's evidence was completed, the CSNSW has tendered documents pertaining to Mr Russell's nine week training programme that indicates that Mr Russell was present on the day when the IIO Form and the reception screening process was taught to the trainees. Mr Russell has reviewed that material and does not take issue with that evidence. I accept that he was present when that training was given. Accordingly, Mr Russell either forgot that he had received that training because it was four years prior to giving his evidence, or he had graduated without having any understanding of it. Whatever the explanation, it is apparent that Mr Russell's induction at Amber

Laurel did not include a refresher about the importance and the requirements of the IIO form[3].

48. Whilst I did not scrutinise any part of CSNSW training I do note that the subjects of reception of prisoners and the completion of the IIO are topics covered in the early to middle part of the training. These subjects could perhaps be repeated or refreshed at the end of the programme to ensure that such an important process is not only one of the first things a trainee learns but is also one of the last things to be imprinted in their minds as they start their first round of duties in a prison or reception centre.

49. There is no issue that Mr Russell demonstrated poor compliance with the applicable policies and training that had been provided to him. Indeed he accepted that, despite the IIO form being quite self-explanatory about what is required of the Officer completing it, he failed to properly do so. In his evidence he suggested that the reason for the incomplete form was because either the prisoner refused to co-operate and answer the questions or he did not understand the questions and required an interpreter.

50. Given the evidence of RN's co-operation with all other screeners and with the police, I reject that the form was not filled in properly because RN did not co-operate. I accept the evidence that RN had basic English skills and that had he been asked at least some of the questions he would have been able to answer them. Mr Russell did not ask the questions. The reason behind Mr Russell's failure to properly perform his role is beyond the scope of this inquest. At least to Mr Russell's credit he said in his evidence "It should have been filled in in its entirety; I have no excuses as to why it was not".

51. Counsel Assisting and Ms de Castro Lopo made submissions in relation to a proposed recommendation aimed at ensuring that officers understand the importance of the IIO and know how to complete the form properly.

52. Ms de Castro Lopo usefully points out that not all officers are sent to the court services and not all officers would be in positions where they would be required

[3] A refresher course would not be expected to be required given that it was Mr Russell's first job upon graduating from Bush Farm

to complete the IIO form on a regular basis. She points out that there are many important training modules and it is difficult to prioritise one over the others to be included in a refresher component. She submits that the suggestion of adding an IIO refresher component in the primary training (at Brush Farm) does not take into account experienced officers who are transferred, promoted or who might work overtime at the court services locations.

53. Given those circumstances there is a need to ensure that any personnel from any pathway who are required to complete the IIO form must be aware of the importance of the task and their training is up-to-date.

54. Ms de Castro Lopo has indicated by letter of 24 October 2019 that CSNSW has an online training programme which I understand specifically includes the Court Services IIO form and procedure. Any officer engaged in tasks involving these duties should be as part of their induction required to, where necessary, undergo a "refresher" by completing that online module.

55. Mr Russell said that for the entire time he worked in this area at Amber Laurel that he never once used an interpreter, heard of any other officer use an interpreter or indeed ever saw or heard that an interpreter service was available to assist in communicating with the prisoner to complete the IIO. Mr Russell said he was not aware of any telephone number being posted anywhere in the office or any procedure involved in using a telephone interpreter. It seems to have escaped Mr Russell's attention over the 12 months in his position that the telephone number for the 24 hour 7 days a week telephone interpreter service is identified and clearly recorded on the IIO form itself. Mr Russell said that he did not think his rank at that time would have entitled him to use an interpreter even if he had known about them.

56. Mr Hayhow was the Officer in Charge at Amber Laurel during the time Mr Russell was working there. He gave evidence that he expected that the IIO form would be fully completed. He also said that the form should have been sent back to Mr Russell by the supervisor on duty so that it could be filled out properly.

57. Mr Hayhow gave evidence that interpreters were used at the centre by officers (regardless of rank) but that there were occasions when he (and other officers)

would get the information required to complete the form “anyway they could” so if another prisoner could translate then he would adopt that course rather than troubling the telephone service in the early hours of the morning. In relation to prisoners telephoning family members, Mr Hayhow said that most prisoners are at Amber Laurel 3-4 days and that if they had not telephoned a family member within the first 72 hours, efforts would be made to assist them in this regard. I note that if RN arrived at about 4 am on 1 April and on that basis he should have had a phone call but as it turned out the phone number recorded (if it was at Amber Laurel) was missing a number. It is not known whether RN tried to call any family when he was a prisoner at Amber Laurel.

58. Counsel assisting submitted that “a culture of inattention to essential detail in the proper screening of inmates had developed” at Amber Laurel. Ms Castro de Lopo submits that the inquest did not investigate any other inmate screenings and accordingly would not make such a finding. I agree but I do note there is a possibility that that there is a cultural misconception that Amber Laurel is perceived as part of the “police cells” even though it is operated by CSNSW.

59. Such a misconception may cause Amber Laurel to be identified as a location at which an adequate intake or screening process is not necessarily required and though the IIO is on the corrections file, it is not necessarily a document about which much care needs to be taken due to the possibility that a prisoner will be granted bail and not proceed to Reception at one of the prisons.

60. Mr Russell said some prisoners can stay as little as 2 hours and some as long as 2 weeks. Whilst that might be the case, the centre is run by CSNSW, not the police, and though the prisoner might or might not be remanded to a prison after their court appearance, failing to complete the IIO and expecting it will be completed by another staff member during the later Reception Process is not compliant with CSNSW policy.

61. Due to the inadequate conduct of the screening process at Amber Laurel it is unclear whether RN, even if he had the opportunity to, and if he had been able to, would have conveyed to Officer Russell that he was at risk of self-harm.

RN's first Court mention and whether Mr Anderson was aware that RN was at risk of self-harm

62. RN was booked to appear in court by AVL on 1 April. Sm attended the Liverpool Local Court and on becoming aware that Mr Anderson was going to represent RN she approached him. Sm told Mr Anderson that she was RN's sister and that RN required an interpreter and as she had been an accredited interpreter she could assist him in the interview. Mr Anderson accepted her offer and they both attended the AVL suite and spoke with RN.

63. Sm says in both her statement and in her evidence that during the legal interview, RN said to her "*I just want to die*" and she replied "*No don't do that.*" She was aware at the time that her emotions had overridden her duty to interpret, and she apologised to Mr Anderson for doing so and said words to the effect of "*He just told me he wanted to commit suicide*. *And I told him not to".*

64. Mr Anderson has given evidence and he has no recollection of RN or Sm but has provided his file notes. Those notes do not contain any record that RN had expressed that he wanted to end his life.

65. Mr Anderson says that if he was aware of such an indication he would write a file note and raise it in court. There was no such file note and the transcript of Mr Anderson's appearance in court on behalf of RN shows that he did not raise concerns about RN's mental health. A comment made by Mr Anderson in court however suggests that Mr Anderson had experienced some difficulties in communicating with RN which may have been due to Sm seeking to converse with RN rather than strictly interpreting.

66. Mr Anderson told the court "*I'd need an interpreter your Honour more…more than his sister better in interpreting than his sister. He understands the seriousness of the matter, that much is understood*". It is possible that Mr Anderson did not appreciate that Sm was conveying to him that RN was threatening self-harm as opposed to Sm apologising for engaging in a conversation rather than strictly interpreting, so that the nature of what RN had said was miscommunicated.

67. It has been suggested Mr Anderson did not lend as much regard as he should have towards the comment due to his workload, however it appears to me that he is well used to being a duty solicitor and it really was a case of a misunderstanding between him and Sm. Mr Anderson said "*I think it very unlikely I would not have reacted unless it was expressed emotionally to me (due to it being) her brother*."

68. I accept that had Mr Anderson been aware that his client was at risk of self-harm he would have made a file note and would have raised it with the court. The court transcript indicates Mr Anderson had seen on some papers that the language RN spoke was Cantonese but he clarified with the court that RN was Cambodian and that a Khmer interpreter was required for the next mention. That attention to detail indicates to me that as busy as he was Mr Anderson was mindful of ensuring that his client received the correct services.

69. Mr Anderson indicated to the Local Court that there was to be no application for bail and he asked that the matter be adjourned to 15 April 2016. The magistrate asked Mr Anderson to convey the outcome to RN. Accordingly, it would appear that RN did not appear in court by AVL on that day but was made aware he would be next attend in 2 weeks' time.

RN's medical treatment at Amber Laurel Correctional Centre

70. Sm said that she took RN's clothes and medication to Amber Laurel but was only allowed to leave the medication. The JH&FMHN Records obtained for Amber Laurel show that RN was reviewed in the holding cell by Registered Nurse Ms Robinson at 4 pm on 1 April. She notes that the medication had been brought in by RN's sister. She obtained his written consent to acquire information about his medical issues and medication from his GP. RN received further medication at his cell door at 10.13 pm that night. He was again reviewed and provided medication at his cell door at 2 pm on 2 April, and again in the clinic on 3 April. Brief reviews on 2 and 3 April note "*no concerns were voiced*" and "*nil issues stated*". I note that though RN was at Amber Laurel and attended to by nurses on these 2 days, there is no evidence suggesting that the nurse commenced a Reception Screening Assessment.

JH&FMHN Assessment at Parklea Correctional Centre

71. On 4 April 2016 RN was transferred to PCC arriving at about 12.45 pm. A process of reception screening is conducted by both JH&FMHN and by CSNSW. Only RN's health screening was performed on 4 April and it did not commence until shortly after 9.30 pm. However, the IIO which had been finalised incomplete by Mr Russell 3 days previously was on file.

72. Ms Howlett, who is an endorsed enrolled nurse, completed the Reception Screening Assessment ("RSA") which is recorded as having commenced at 9.34 pm and completed at 10.00 p.m. That form already had some electronically entered information in a section called "Patient Background" under which the field about "Country of birth" was recorded as "unknown", and that "no interpreter was required".

73. Those fields are derived from the IIO and if there is an error it can only be changed by a process involving the screening assessor completing a special form and sending it to sentence administration. Given that the IIO was barely filled out by Mr Russell, it is not surprising that RN's country of birth is recorded as "unknown" but the record that "No interpreter required" was inconsistent with Mr Russell having ticked twice that one was required, though incorrectly stating Cantonese. There is no evidence that any attempts had been made to correct the fields by a screening officer. I note that Ms Howlett is not a screening officer employed by CSNSW but rather she is employed by JH&FMHN.

74. As a result of her assessment of RN, at 10.07 pm Ms Howlett completed a form called "Health Problem Notification Form ("HPNF") which was a notification to CSNSW/GEO that RN was an inmate with special needs and that he should be in a two out cell placement because it was his first time in custody and he was Cambodian with limited English. A CSNSW receiving custodial officer, T. Mosokon, acknowledged receipt of that form on 4 April[4].

[4] RN was accommodated in 3 cells over the 4 days he was at PCC. He started in cell 11 in 3A Wing, then on 6 April he was moved to cell 23 in Wing 3A and finally on 7 April 2016. In each cell he was placed 'two-out', that is, with a cell-mate.

75. Ms Howlett said that she felt she was able to adequately communicate with RN. During her half hour with him Ms Howlett weighed and measured RN, took and recorded his vital observations. She obtained details from him about his General Practitioner. She completed the RSA which included conducting the Kessler 10 Test which is a mental health assessment check. She completed a health notification form.

76. Ms Howlett gave evidence that she was able to communicate with RN, she had asked him whether he would like her to call the interpreter telephone service and he declined. She made a note that if you spoke clearly and slowly he could understand. This is consistent with RN having basic English skills. Though there is no record of having done so (as there should have been) I accept Ms Howlett's evidence that she asked RN if he wanted her to call a telephone interpreter and that he declined. Ms Howlett's omission to record so was not compliant with the applicable policy.

77. It is unclear why RN declined an interpreter. He had requested one at the police station. He did not have an interpreter at Amber Laurel. His sister acted as interpreter at the court. It is unclear whether he understood sufficiently or whether he understood enough and did not want to inconvenience any interpreter given the time of night or did not want to experience further delay getting to whatever cell he was being allocated as he had been waiting at PCC reception for over 8 hours to be processed.

78. RN was able to tell Ms Howlett the medications he had for cold sores, high blood pressure and that he had no other major medical conditions, that he was not a drug, alcohol or tobacco user and that he did not take any prescribed or non-prescribed opioids. Ms Howlett indicated on the form that RN was neither intoxicated nor withdrawing.

79. Ms Howlett administered the Kessler 10 mental health safety test. The test provided a score which indicated that RN may currently **not** be experiencing significant feelings of distress. Ms Howlett commented on the form that RN's presentation was congruent with that score, that it was his first time custody; he had limited English, but that he understands if you speak clearly and slowly.

80. Ms Howlett noted that RN denied any thoughts of self-harm or suicide. He identified he had a sister for support, was a non-smoker, had a history of hypertension, elevated cholesterol and his mood was sad. Ms Howlett was of the opinion that he should be "2 out" (that is, he should be accommodated in a cell with another prisoner in preference to being alone).

81. Ms Howlett recorded that RN had indicated that he had never been treated for a mental health problem, or tried to hurt himself, or tried to end his life or anyone in his family had. Under patient concerns Ms Howlett recorded that RN was worried about the future as his wife may leave him. Ms Howlett said that in answer to the question *"How do you think you will cope with prison?"* RN replied *"I don't know".*

82. Of note in the Kessler 10 test there is a series of questions about whether in the last 4 weeks he had felt "depressed, worthless, that everything was an effort and so sad that nothing could cheer him up". To each of those questions RN had answered "*a little of the time*" (which is one of the 4 options available). It is not clear whether this was because he had only had those feelings since he had been arrested or whether some other explanation was available. The form does not record any explanation of this other than the words "*mood sad*" but does record that "*patient denies any thoughts of self-harm suicide*".

83. It is unclear whether, due to the time of night and the lack of English, RN fully understood the nature and the importance of the assessment Ms Howlett was engaging him in. It may well have been safer, as well as simply prudent, to seek the assistance of at least a phone interpreter and/or refer him for further assessment by a mental health nurse.

84. Following Ms Howlett's screening a request for information from his doctor was sent and RN's G.P responded on 6 April 2016. The response confirmed RN's medications and the response did not raise anything from his past medical history suggesting an issue with self-harm, depression or suicidal thinking.

85. RN was placed on the JH&FMHN Patient Administration System (PAS) on 4 April for routine follow-up within 7 days by the 'population health' nurse specialty and within 8 days (non-urgent) for the Primary Health Nurse specialty.

86. At about 1 pm on 7 April 2016, RN attended the primary health nurse at the clinic where his blood pressure and pulse were checked. No note is made of any concerns and the identity of the nurse is not recorded.

87. Since April 2016 the RSA has undergone a review and Associate Prof Dean provided a statement commenting on the current procedure and the proposed procedure.

Screening by GEO Corrections Personnel

88. On 4 April before RN was assessed by Ms Howlett he saw Mr Petkovic who placed a number of forms in front of him, explained in a nutshell what they were and asked RN to sign them which he did. The forms contained legal language and were like basic contracts whereby the prisoner acknowledges responsibility not to damage property and the like. Mr Petkovic said that he asked RN if he would like an interpreter and RN said that he would. However, Mr Petkovic determined that RN did not need an interpreter so did not organise one. On reflection Mr Petkovic was of the view that he should have ordered one and he had even thought that RN might need an interpreter for the ISQ which was also required to be completed. I am satisfied that RN signed documents at the request of Mr Petkovic and it is unlikely that he understood fully what it was he was signing.

89. Mr Petkovic suggested that the reception and screening centre is a high-pressure environment with people queuing up. Ms Howlett said that she might process up to 10 prisoners a shift though she said she felt no time pressure to finish RN's assessment for her to finish her shift on time (10 pm). Given that RN was there for 8 hours it seems that prisoners may be processed in circumstances which, due to time constraints, results in at least persons with a basic level of English being disadvantaged by not having an interpreter made available to assist them with such forms.

90. RN was screened by Corrections Officer Mr Pauu on 6 April 2016. On one of the forms is a phone number for Sm but it does not contain sufficient digits. Either that phone number or another number subsequently provided by RN was called

by Mr Pauu, but the number didn't work. Mr Pauu is now deceased and cannot shed light on what number he relied on, but no other number is noted on the available forms. A GEO spokesman, Tony Mannweiler, identified that the deficient phone number resulted in a referral for Offender Services to try and contact a relative on RN's behalf. Unfortunately, RN did not have the opportunity to speak with his sister Sm or any family member before he died.

91. An intake screening questionnaire ("ISQ") was completed by Mr Pauu. The form suggests that the 87 questions were asked and answered between 12.59pm and 1.10pm. Mr Pauu's supervisor, Mr Wayne Bradley, suggests that this must be an error as it would not be possible to ask those questions in that time frame. The form requires the officer to consider using an interpreter. An interpreter was not used. Question 52 notes that when asked how he was feeling, RN replied "feel a bit sad". No further note is made of what precisely this meant or any exploration of it. RN apparently denied any thoughts of self-harm or to take his own life.

92. On 6 April 2016 the ISQ was reviewed by GEO Group employee, Karen Morton. She did not detect any indicators of suicide risk in the Questionnaire. She noted RN had limited English. She did not interview him. In her statement Ms Morton said she looks at the following things when assessing whether an inmate is at risk of self-harm: the inmate's profile document (this would have been insubstantial given he had only just come into custody for the first time), the court records (also limited) and the ISQ.

Policies about Screening and Reception of Prisoners

93. The policy applying to JH&FMHN screening after RN's death is called "Health Assessments in Male and Female Adult Correctional Centres".[5] It notes that the triage of the inmate's immediate health needs is the focus of the initial assessment in the cells[6]. It also suggests that registered nurses working in the police cells would create a Reception Screening Assessment ("RSA").[7]

[5] Vol 2 Tab 81.
[6] Vol2 Tab 81 at 2.1.1
[7] This did not occur at Amber Laurel though RN was attended to by nurses on 2 and 3 April. There is no evidence relating to these days other than that RN was provided the medication his sister Sm had brought in.

94. The policy requires that a Registered or Enrolled Nurse must complete an RSA for all patients entering correctional centres[8]. The policy appears to be silent as to the use of interpreters. Ms Barbara Ball, Acting Nurse Manager Operations from JH&FMHN, annexes the policy at the time of RN's death to her statement.[9]

95. The policy relating to the use of interpreters is found elsewhere, in a document called 'Health Care Interpreter Services-Culturally and Linguistically Diverse Patients', which was issued in 2013[10]. It variously provides that: (i) if an interpreter isn't available, it has to be logged on the Incident Information Management System ("IIMS"); (ii) if a patient identifies as non-English speaking, or if a language other than English is spoken at home, this requires the services of an interpreter and must be noted on the Health Problem Information Form and as an alert on PAS[11]; and all patients who are not fluent in English must be informed about their right to access a professional health care interpreter at first point of contact and on an ongoing basis[12].

96. Both the Health Care Interpreter Service and Health Language Services offer a 24hr/7 day service. Accordingly, when an assessment is carried out after hours such as in RN's case an interpreter should still be used rather than the nurse making a judgment call (as suggested by Ms Ball in her statement)[13].

97. A flowchart in the policy allows that when an interpreter is not available a staff member or patient could be used to interpret suggesting that only questions essential for the patient's health and safety, presumably until a full assessment with the assistance of an interpreter can be completed.

98. Health staff are encouraged to use their judgment to decide if an interpreter should be used and how they exercise that judgment seems to depend on what the issues to be communicated at the health appointment are. Of course if a practitioner asks a prisoner if they would like an interpreter and the prisoner declines a prisoner has a right to their privacy. However, if the practitioner is

[8] At 3.2.1
[9] Tab 144 attachment 2; relevantly, it appears to be in substantially similar terms to the successor policy, albeit with different numbering.
[10] Tab 44 attachment 3.
[11] page 2;
[12] page 4 and 3.4.
[13] Tab 44 para 23

unable to elicit sufficient information they should organise an interpreter to at least discuss that issue so that the prisoner understands why an interpreter should be used, regardless of what the prisoner has indicated. To do so would not be a breach of the prisoner's privacy but rather an adoption of best practice so that the practitioner is confident that their purpose is understood by the prisoner.

99. Associate Professor Dean gave evidence about the implementation of a proposed new screening policy from the from JH&FMHN perspective designed to improve screening for persons who have mental health issues such as depressed mood. Associate Prof Dean considers that the Kessler 10 test may not have been as effective as it was intended to be.

100. Ms Lucia Boccolini, co-ordinator of the CSNSW Reception Screening and Induction Assessment and Case Management Support Team, gave evidence about the current CSNSW policy, including the requirement that interviews be conducted in a language that the inmate understands (as it is critical to record accurate information) and has provided an extract of the relevant Operations Procedures Manual ("OPM") applying at the time of RN's death, specifically clause 7.15.3.4 of the 'Guidelines for Telephone Interpreting'. The policy includes that interpreters be used *"whenever it is felt that the inmate may be disadvantaged without the services of an interpreter"* or where there is any doubt about their ability to comprehend or express themselves in English.

101. The fact that from time to time, relatively sophisticated terms are used in the screening process and that it is a very important exchange between the inmate and the prison, it would be prudent to utilise the services of an interpreter when an inmate has basic or limited English Language skills. Apparently about 5% of the NSW prison population have English as a second language which would suggest that most staff members of Reception and screening areas would be, or should be, very proficient in using interpreters so that those prisoners are not disadvantaged. I suspect that best practice is likely compromised at times by the dictates and pressures imposed by the demands of a busy engagement. Whether that was the case for RN is difficult to determine but it seems likely given that it was a process involving at least 8 hours.

102. I note that after seeing the Registered Nurse in the clinic on 7 April, RN attended the legal interview with the lawyer Mr Munzenreider which had been arranged by Sm. That interview was also held without an interpreter. Mr Munzenreider was with RN for about half an hour and said in his statement that RN spoke in "broken English" but he was confident that RN understood the conversation.[14] He said that RN did not raise anything which suggested that he was at risk of self-harm.

103. It is not clear when RN formed the intention to end his life but it may have been at the least the day prior as that is the date of one of the letters he wrote. Though it is clear that RN spoke and understood sufficient English it is unclear whether he would have done so to tell someone about how he was feeling which would trigger a full mental health assessment. It is not possible to confidently identify that his language skills were a barrier to him doing so.

104. I do note that Ms Howlett formed the view that RN's relationship with his sister would be a supportive and protective factor and Ms Howlett believed that RN would be able to contact Sm so it would be an effective factor. However, RN was not able to contact Sm and it was only on 6 April that an unsuccessful attempt was made.

105. RN took his life after a week of incarceration. During that week he had been processed by numerous people without an interpreter, on the first occasion Mr Russell asked no questions of him at all, on the next occasion with Mr Petkovic he was at least asked if he wanted an interpreter but when he said "yes" he was denied an interpreter. Perhaps when he declined Ms Howlett's offer of an interpreter he thought that is what he was meant to do.

106. RN moved cells constantly and he did not have a telephone call with any family member. He did not appear in court even on AVL. I do not think that the entire processes of that week could be described as being conducive to good mental health for a middle aged person who had never been in custody before but at least had English as their only language, let alone a person who had basic or broken English skills.

[14] Vol 1 Tab 16 para 120

Hanging Points in Parklea Corrections Centre

107. Shortly after RN and his cellmate were locked in their cell for the night, the cellmate went to sleep and RN was finishing his goodbye letter to his family. He then went into the bathroom and hung his sock over the shower rail. Since RN's death there have been a number of inquests in relation to hanging points at PCC (and other) Correctional Centres. The shower rails and other identified points have now been removed. Accordingly, this inquest has not focussed on this issue.

Response Time to Attend to a Distress Alarm in 3A Wing

108. After RN's cellmate woke up and discovered RN deceased, the cellmate pressed the alarm. The alarm is heard in the control room which has monitors showing all areas of the prison which housed at that time a little fewer than 1000 prisoners. Only one person staffed the control room. All cells are equipped with an alarm button. It is a constant challenge to determine which calls are genuine and which are not. At the time of RN's cellmate's alarm, another incident was occurring at another location and the control room operator determined that she needed to watch that incident unfold in case further staff assistance was required.

109. RN's cell alarm was responded to after a delay of about 15 minutes. This issue was adequately investigated by the GEO Group at the time. As a result, overnight control room staffing levels have doubled so that one staff member is solely responsible for answering the alarm calls and keeping the log of Stenofon use.

110. The evidence indicates that RN was likely deceased for some time when he was eventually responded to. He is described as 'cold to the touch' by several attending staff. He could not be revived. This should not detract from the need to provide as urgent a response as possible in similar tragic situations. I have heard from the witness who operated the control room that night. However, given the changes made to the response to the Stenofon alarms, it is not an issue which has concerned this inquest.

Parklea Under New Management

111. Since RN's death the operation of PCC and the provision of health services there have passed from GEO and JH&FMHN, to Broadspectrum and St Vincent's. The overall monitoring of policy compliance is conducted by CSNSW. The use of interpreters is to be encouraged in Broadspectrum's screening and reception processes.

112. JH&FMHN has a new policy which sets out that an interpreter should be used when the prisoner is "not fluent" in the English language[15]. In other words, unless a patient is fluent in the English language an interpreter should be used. In addition to the same policy, St Vincent's has an extra guide whereby it advises that to assess whether a patient is fluent, one can take into account whether they hesitate or have difficulty in understanding and communicating in English.[16]

Recommendations

113. Counsel Assisting's proposed recommendations were circulated with his closing submissions. The first set is directed at CSNSW and the second to JH&FMHN.

114. In relation to CSNSW, Counsel Assisting proposes recommendations directed to Amber Laurel Corrections Centre:

    (i) Recommend that remedial training be provided to officers at Amber Laurel correctional centre involved in completing '*Inmate Identification and Observation*' forms as to the importance and reasons for completing such forms and the use of interpreters in line with CSNSW Custodial Operations Policy and Procedures 11.1 Language Services; and

    (ii) Recommend that consideration be given to developing a policy requirement for inmates, who are detained in custody for the first time, and housed at Amber Laurel correctional centre for more than 48 hours prior to movement to a reception centre, to be offered (and, if accepted, provided with) a telephone call to a nominated family member.

[15] Policy1.230:2019
[16] See A/Prof Dean's evidence T5 July 2019, pp24-26

In relation to JH&FMHN, counsel assisting proposes:

To the Director, NSW Justice Health and Forensic Mental Health Network:

(i) That consideration be given to amending the current version of the Justice Health policy '*Health Care Interpreter Services-Culturally and Linguistically Diverse Patients'* to provide guidance as to the need to offer telephone interpreter services to a patient who lacks fluency in the English language. This may include by incorporating the words: "Firstly, as a guide, a patient can be said to be not fluent in English if they hesitate or have difficulty in understanding or communicating in English", or such other formulation as is deemed appropriate by Justice Health.

115. The evidence in this inquest does not readily indicate that such a change is required because Ms Howlett completed a reasonably comprehensive RSA after RN declined the services of an interpreter and she was sufficiently mindful of his basic English and adapted her language to ensure effective communication. Alhough she did not record that she had offered an interpreter and that he had declined, Ms Howlett did record that his ability to communicate required the assessor to speak clearly and slowly.

116. Ms Howlett, an experienced screening nurse, appropriately assessed that RN was vulnerable as a middle aged first time prisoner with basic English. She identified the protective factors, his mood and his uncertainty about how he would cope with prison. She booked him in to see the nurse within seven days and she provided in that notification that he should be accommodated in a cell with another person.

117. JH&FMHN submits that if there were any shortcomings in the screening process they were not because RN had basic English but rather possibly due to the shortcomings of the Kessler 10. The mental health screening is greatly changed since then with the implementation of a new mental health screening test.

118. Mr Bradley submits that St Vincent's guide that a patient's hesitation in responding to a question could demonstrate a lack of fluency of English

language is of equivocal assistance and as such does not warrant the change in policy as suggested in the recommendation. On balance I agree with that submission. As Mr Bradley points out, Clause 2.1 states that "health care interpreters are to be engaged in all healthcare situations where communications are essential for patients/clients who are not fluent in English…". The guide, at Clause 2.3, states "to assess if the patient is able to fully understand and communicate in a health care situation. Just because they can manage to give you their personal details and talk about every day topics such as the weather, do not assume they have enough English to cope in a medical situation".

119. On the basis that it is clear that a RSA process is a "healthcare situation" I am of the view that the policy is probably more helpful to understand the meaning of fluency than whether the patient "hesitates". The policy clearly identifies that an interpreter should be used in circumstances where the patient has basic or less English language skills. Accordingly, I determine that such a recommendation, on the evidence of this inquest, is not required and I decline to make it.

120. I note that Ms Cooper supports Counsel Assisting's proposed recommendations directed at Amber Laurel Corrections Centre. Ms de Castro Lopo submits that the evidence falls short of establishing that the inaptitude of Mr Russell is symptomatic of the culture at Amber Laurel. Given that the screening took place three years ago, I hope she is correct. However, it appears that Mr Russell was not the only staff member who paid disregard to the requirements of the IIO – so too did his supervising officer.

121. I note that there is no evidence about why an RSA was not commenced while RN was housed there, as I surmised earlier I suspect that staff are influenced by the guaranteed transience of their inmates and if the inmate proceeds in the prison system further screenings are likely to be fully carried out at that stage. I also note that since that time CSNSW has introduced an auditing process designed to identify shortcomings in their processes. Perhaps, though without a specific recommendation, if an audit has not yet occurred at Amber Laurel it should now be performed to ensure that there is no longer the shortcomings in the screening process as there was at the time RN entered the facility.

122. I have already dealt with the issue of training officers about the importance of completing the IIO and am aware that there is an ongoing process of review and improvement. I thank Ms de Castro Lopo for her assistance in regards to this recommendation. I note that her advice in her letter dated 24 October 2019 that "There is a Course available on the CSNSW Learning Management System – Reception Operations (For 1st Class Correctional Officers)"[17].

123. On that basis, I decline to make the recommendation sought by Counsel Assisting but I do encourage CSNSW to ensure that all Officers who are engaged in the Reception Screening Process, if necessary, to have a "refresher" by undertaking the on-line learning module.

124. Ms Cooper submitted strong support that an inmate at Amber Laurel is able to make a telephone call within 48 hours. She says "The family believe both a telephone call and the use of interpreters would have reduced RN's sense of isolation and that the family hope that steps are taken to improve these services for future inmates".

125. The isolation of a prisoner, particularly in RN's circumstances should not be underestimated, and whilst the screening procedures by both CSNSW and JH&FMHN are designed, in part to identify prisoners at risk of ill mental health and/or at risk of self-harm, and though those screens are "but a moment in time" they are the primary tool currently utilised.

126. In many ways making an interpreter available to a person who clearly struggles with English shows a powerful message to the prisoner and that is, someone cares enough about him that they want to make sure that he understands what his rights are, what services are available to him and who he can ask for help. Frankly, they seem to me to be basic human rights for persons who are incarcerated no matter what their cultural or linguistic background.

127. I am fairly certain that RN did not know that he could or did not know how to ask for help. When, after 6 days a telephone call to Sm was attempted but failed[18] he

[17] Ex 11

[18] Because someone had written down an incorrect number without paying sufficient regard to notice that it was a digit missing.

may well have given up. A prisoner should be able to make a telephone call to a family member or friend within 24 hours and 48 hours at the latest.

128. Ms Janet de Castro Lopo confirmed in writing by email and a later letter both dated 24 October 2019 that *"This process has already been developed at Amber Laurel since this serious incident. Welfare staff from Emu Plains are also used where necessary to assist with inmate welfare calls and issues. Although there is no facility for Offenders*[19] *to make a phone call unless Welfare Staff have been called to assist, the staff at Amber Laurel will contact Offenders relatives at the Offender's Request".*[20]

129. Ms de Castro Lopo submits on behalf of the Commissioner that due to this change the recommendation is not required. I disagree. Though the difference may be subtle, I think that a prisoner being able to speak personally to a loved one, particularly in their own language, is a far more protective factor than being told by a prison officer or a welfare officer that contact has been made and a message passed on. If the recommendation requires infrastructure change so that telephones need to be installed for this purpose then the recommendation should be read as such.

130. **To the Commissioner of Corrective Services NSW**

I recommend that consideration be given to developing a policy requirement for inmates, who are detained in custody and housed at Amber Laurel Correctional Centre prior to movement to a reception centre, be provided with a personal telephone call to a nominated family member preferably within 24 hours but certainly no later than 48 hours .

131. Perhaps an interpreter would have made a saving difference; perhaps a telephone call would have as well. Ultimately, the letter written by RN doesn't speak about his experience in the prison but rather his regret and sorrow of the actions he committed against his wife and ultimately his family. It is unclear how

[19] Offenders should read prisoners especially as most Amber Laurel inmates are on remand or yet to make their first Court appearance.
[20] Ex 11

much his experience in the prison system over the preceding seven days impacted upon RN's inability to see a future for himself after realising that his marriage was over and he had lost his cherished family, an experience he had previously suffered whilst a young person in Cambodia due to the terrors of the Khmer Rouge.

132. I now enter the following findings:

Identity
The person who died is known as "RN"

Date of Death
RN died on 7 April 2016

Place of Death
RN died in the bathroom of his cell at Parklea Correctional Centre, Quakers Hill NSW

Cause of death
RN died as a result of asphyxiation by ligature

Manner of death

RN's death was intentional and self-inflicted in circumstances where he was a recent remand prisoner at Parklea Correctional Centre.

133. I again pass on my sincere condolences to RN's family.

Magistrate E Truscott
Deputy State Coroner
25 October 2019