CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SB
Hearing dates:	16 – 19 November 2020
Date of findings:	11 December 2020
Place of findings:	Coroner's Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – mandatory inquest – death in custody – Parklea Correctional Centre –cause of death – adequacy of mental health care – appropriateness of cell placement - hanging points
Non-publication and non-access orders:	Pursuant to s. 75(1) of the *Coroners Act 2009*, there be no publication of the name or any other matter which may lead to the identification of the deceased person, the de facto partner of the deceased, or any relative of the family of the deceased. Pursuant to s.74(1)(b) of the *Coroners Act 2009,* an order was made that there be no publication of specified portions of the brief of evidence (exhibit 1). A copy of the order is available on the Registry file.
File number:	2017/100899

Representation:	Mr Ian Fraser, Counsel Assisting, instructed by Mr Paul Crean of the Crown Solicitor's Office. Mr Stuart Littlemore QC instructed by Peter Woodhouse of Aulich, for the SB family. Mr Patrick Rooney, instructed by Ms Kate Hinchcliffe of Makinson d'Apice Lawyers, for Justice Health and Forensic Mental Health Network. Ms Reg Graycar, instructed by Mr Valentino Musico of the Office of the General Counsel, for Corrective Services NSW. Mr Joshua Raftery, instructed by Ms Melanie Shanahan of Sparke Helmore for GEO Group Australia Pty Ltd. Mr Stephen Barnes, instructed by Mr Paul Tsaousidis of Avant for Dr Balzer. Ms Kim Burke, instructed by Ms Chandrika Darroch of Meridian for Dr Malik.
Findings:	**Identity of deceased**: The deceased person was SB. **Date of death**: SB died between 5:52pm on 2 April 2017 and 8:07am on 3 April 2017. **Place of death**: He died in his cell at Parklea Correctional Centre, Quakers Hill NSW. **Manner of death:** The death was intentional and self-inflicted, in circumstances where he was an inmate at Parklea Correctional Centre. **Cause of death:** The medical cause of the death was asphyxiation by ligature.

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The Coroners Act 2009 (NSW) in s81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of SB.

Introduction:

1. SB was a remand prisoner at Parklea Correctional Centre ("Parklea") at the time of his death. Shortly after 8am on 3 April 2017 he was found hanging in the doorway of his cell by prison sweepers. He had left what appears to be a suicide note. He had last been seen shortly before 6pm the preceding evening.

2. At the time of his death SB was alone in his cell. His usual cellmate had been transferred to attend court the morning prior to his death.

3. SB was 38 years old (born on 18 June 1978). It was his first time in custody, and he faced serious criminal charges. He had raised various issues relating to his mental health with prison psychologists and Justice Health, and had been prescribed medication initially by a general practitioner, and later a psychiatrist.

4. SB's parents, sister and partner attended the inquest and their love for SB was clear. They each continue to grieve the loss of SB and I extend my sincere condolences to the family.

The Inquest:

Nature of an inquest

5. This inquest is a public examination of the circumstances of SB's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing.

6. The primary function of an inquest is to identify the circumstances in which

the death occurred.

7. The role of a Coroner, as set out in s. 81 of the Coroners Act 2009 (NSW) ("the Act"), is to make findings as to the identity of the person who died, the date and place of the person's death, and cause and manner of death. The manner of death refers to the circumstances in which the person died.

8. Pursuant to s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. This involves asking whether anything should or could be done to prevent a death in similar circumstances in the future.

9. During the coronial investigation, sufficient documentary evidence was gathered to answer the questions about SB's identity, the date and place of his death and the medical cause of his death. The inquest was therefore focused on the manner of SB's death.

The proceedings

10. The inquest into SB's death was held at the Coroner's Court of New South Wales at Lidcombe from 16 – 19 November 2020.

11. An issues list was distributed in advance of the inquest, which included the following:

    a. *The psychiatric and psychological care and/or treatment provided to SB by Justice Health, Corrective Services NSW (CSNSW) and/or GEO Group at Parklea Correctional Centre in 2016 and the adequacy and appropriateness of that care and/or treatment.*

    b. *Consideration of relevant policies, procedures or protocols (hereafter "policies") of Justice Health, CSNSW and/or GEO Group regarding a prisoner's mental health care and/or treatment, including policies relating to the communication between the three entities of such issues, and whether those policies were adhered to, and the adequacy or otherwise of them.*

c. *Whether the cell placement and observation of SB was appropriate and/or sufficient.*

d. *The presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea.*

e. *Relevant policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide, including whether the requirements of those policies were met, and the adequacy or otherwise of those policies.*

f. *Whether any recommendations from the Coroner are necessary or desirable, including for prisoners' health and safety*

12. SB's family was particularly concerned to understand whether SB had been properly diagnosed and prescribed the appropriate medication for his mental health concerns.

13. In preparation of my findings, I have been assisted by the oral submissions of counsel assisting, as well as those made on behalf of the family and other interested parties, and the written submissions of Mr Rooney on behalf of the Justice Health and Forensic Mental Health Network ("Justice Health").

The Evidence:

Background:

14. SB was born and lived most of his life on the South Coast of NSW. He was the youngest of four children. His parents were the operators of a holiday resort. SB left school after year 10, and after a period working in the Snowy region and as a mechanic, SB joined the family business.

15. SB met his partner in his early 20's. They had two children together, a son now aged 13 and a daughter now aged 9.

16. At the time of his death SB was a remand prisoner at Parklea Correctional Centre in north-western Sydney. SB had been charged on 19 November 2016 with serious sexual offences alleged to have been committed against his son.

Following his being charged, SB was refused bail by the Local Court. An interim AVO was also in force, which (among other things) prevented any contact between SB and his son.

17. At the time of SB's death, Parklea was operated by the GEO Group Australia Pty Ltd on behalf of the Commissioner of Corrective Services. As of 1 April 2019, that arrangement concluded, and Parklea is now operated under a similar arrangement by the MTC Broadspectrum consortium ("MTC Broadspectrum").

18. At the time of SB's death, the majority of health services at Parklea were provided by Justice Health pursuant to a tripartite agreement between the Commissioner of Corrective Services, Justice Health and the GEO Group. Justice Health, or the Justice Health and Forensic Mental Health Network as it is formally called, is a Statutory Health Corporation established under the Health Services Act 1997. Under the tripartite agreement Justice Health was responsible for the provision of a range of health services, including general health services, mental health services and drug and alcohol services. Relevantly, psychology services were not provided by Justice Health. Rather, psychologists at Parklea were employed by GEO.

19. Health services at Parklea are now provided under a contract by St Vincent's Correctional Health. Pursuant to that arrangement, St Vincent's provides all mental health services, and all health services previously provided by Justice Health, albeit with continued oversight by Justice Health. According to the evidence of Julie Ellis, Director of Operational Performance Review Branch for CSNSW, the psychological mental health assessments carried out in SB's case by GEO psychologists, would now be carried out by St Vincent's clinicians.

Medical History:

20. SB had a history of difficulties with alcohol and insomnia prior to his arrest and incarceration. There were also reports of blackouts or unconscious events.

21. SB had attended alcoholics anonymous at times, but in the period leading up to his arrest, he had been regularly drinking significant amounts of alcohol.

22. In 2009, SB had been prescribed antidepressants (mirtazapine) by his GP, during a period in which he had separated from his partner. This appears to have been the only time prior to his incarceration in 2016 that SB was prescribed antidepressants.

Arrival at Parklea:

23. On the afternoon of 19 November 2016, SB was received into the custody of Corrective Services NSW. Documentation completed on his entry into custody indicated that he required an interview for placement due to the nature of the charges he faced. It was also identified that it was his first time in custody. No medical or mental health concerns were identified at that time.

24. Justice Health completed a 'D&A and MH Summary for RSA for CSNSW' electronic form in which it was recorded that SB consumed alcohol most days, on average 3-4 beers. The form lists the assessment date as 19 November 2016. It was recorded that SB last consumed alcohol on 18 November 2016. It was also recorded that SB had never been treated for a mental health problem, had never tried to hurt himself and had never tried to end his life. The form also recorded under 'Patient concerns' that SB was concerned about being granted bail.

25. On 25 November 2016, SB was transferred to Parklea. He was placed in protective custody due to the nature of the offences he was charged with.

26. At approximately 2000 hours on 25 November 2016, SB was seen by a Justice Health nurse and a Health Problem Notification Form ("HPNF") was completed. It was again identified it was SB's first time in custody. The following was noted "Observe for vomiting, tremors, agitation, flulike symptoms, unsteady gait, may c/o stomach cramps – alcohol withdrawals". Under the heading 'What the CSNSW/GEO officers need to do' reference was made to "2 out cell placement for 2 weeks then NCP". The phrase '2 out cell placement' means that an inmate is to be housed with another inmate. 'NCP' refers to normal cell placement, which means that an inmate may be housed either on their own ('one out'), or with a cellmate ('two out').

27. On 29 November 2016, SB was moved to Area 3B cell 3.

28. On 1 December 2016, SB completed a 'Patient Self Referral Form', which was submitted to Justice Health. SB complained of insomnia and said that he was stressed and feeling "vague and weird". SB was placed on the waitlist to see a GP.

29. On 12 December 2016, SB completed another 'Patient Self Referral Form'. He again complained of difficulties with sleep and said that depression was an issue for him. He asked to see a doctor. He was noted to already be on the waitlist.

30. On 24 December 2016, SB completed a further 'Patient Self Referral Form'. SB referred again to his sleep difficulties and said that he was having "bad thoughts" at night. He was again noted to be on the waitlist to see a GP.

31. On 30 December 2016, Clinical Nurse Consultant ("CNC") Ford was copied into an email in relation to booking an MRI for SB and arranging the necessary referral.

32. On 2 January 2017, SB completed a fourth 'Patient Self Referral Form', in which he complained of neck problems and headaches.

33. On 11 January 2017 SB contacted the Justice Health mental health line requesting mental health review for increasing insomnia and depression. Arrangements were made for SB to see the mental health nurse.

34. On 12 January 2017, a Mental Health Triage form was completed by RN Robyn Osborne. The reason for referral was listed as "3 x self-referrals + MH calls". SB reported poor adjustment to the custodial environment. He also reported his previous use of antidepressants and said he would rather not take medications. SB was referred to psychology and to a GP. RN Osborne also provided SB with information in relation to the cell call and the self-referral processes at Parklea.

35. RN Osborne emailed the GEO Group Head Psychologist, Dr Lutchman, to refer SB for psychology. She also referred SB to a Justice Health GP to assess

possible antidepressant treatment.

36. On 19 January 2017 SB was placed in in cell 6 of area 2C (a wing reserved for protected prisoners). From this date until the morning before his death, SB shared this cell with another prisoner, TM.

37. On 25 January 2017, SB underwent an MRI of his brain at Blacktown Hospital. This had been recommended by his community GP.

38. On 28 January 2017, SB completed a 'Patient Self Referral Form' stating "I am very depressed all the time. I have been in jail 2 months plus and I am still struggling mentally & emotionally. I have only been on depressants once before but now I feel I really need help. I would never hurt myself but I honestly cannot fix my mental thoughts and I am just down all the time. Please please help!"

39. On the same day, RN Sunderland made an entry in the clinical records in respect of a phone call received from SB's family with concerns for his wellbeing. It was noted that morning and night staff attempted to have SB attend the clinic, however, he did not attend.

40. On 29 January 2017, RN Sunderland made an entry in the clinical records noting that further attempts were made to see SB. SB did not go to the clinic when he was called.

41. On 30 January 2017, an entry by RN Cole, noting that SB was seen that morning. SB stated that he was feeling depressed and was not sleeping well. He said that previously he was a big drinker and was on antidepressant medication for a short time many years ago, but experienced side effects. RN Cole's impression was "presents as anxious, needs review." The plan was that SB was placed on the GP list for the next day.

42. On 31 January 2017, an entry was made in the clinical records by Dr R. Balzer, general practitioner. SB reported feeling depressed, and not sleeping well. Dr Balzer prescribed Mirtazapine 30mg, which is also known under the brand name Avanza. Dr Balzer told the inquest part of the reason that he chose mirtazapine was for its dual effect as an antidepressant and as an aid

for sleep.

43. On 3 February 2017, a nursing entry was made in the clinical records. The note records that SB had good eye contact, was cooperative and interacted well. A history of depression was noted and that SB had been reviewed by a GP with medication commencing on 31 January 2017. SB reported he was feeling "okay" but would like to wait for the medication to work. SB reported that he had no thoughts of self-harm due to his thinking of his partner and two children. SB stated that he never mentioned any suicidal thoughts to anybody.

44. SB was first seen by a psychologist on 15 February 2017 when he was seen by Ms Cathy Yu, a GEO psychologist. SB had been referred to her for anxiety. She recorded that SB presented as moderately distressed. He reported a history of severe anxiety and alcohol abuse with episodes of blackouts. SB reported compliance with his medication. He denied thoughts, plans or intentions to harm himself or others. SB stated that he previously had fleeting thoughts of suicide but acknowledged his family as a significant protective factor. SB reportedly denied any thoughts or plans of hurting himself, and guaranteed his safety. Ms Yu recorded the following; "Referral triaged to PSYCH1 to follow up. Inmate reminded of self-referral process, and agreed to self-refer should mood deteriorate further before next seen".

45. Ms Yu said in evidence that all she had at the time of seeing SB was the referral. She did not have access to the Justice Health file and notes. On reviewing her notes, Ms Yu said that she assessed SB as being at low risk, and that this assessment was essentially triage. She said that the PSYCH1 line triaged an inmate for follow up at the highest priority. In evidence Mr Pietersen, another GEO psychologist, said that explained that the PSYCH1 line was for suicide/self-harm, and that a person should be followed up again within two to three weeks.

46. On 16 February 2017, SB's father wrote to Justice Health noting that SB was not well. He noted that he and his wife were watching SB's health deteriorate. SB had been subject to blackouts and suffered from insomnia and panic

attacks. The letter said that SB had been given antidepressants, which only served to exacerbate his condition. SB's father stated that SB required specific medical attention and an appointment had been arranged by SB's family to see a sleep disorder specialist on 21 February 2017.

47. On 17 February 2017 SB again saw Dr Balzer. SB said that he was continuing to experience low mood. Dr Balzer increased the dose of mirtazapine to 45mg and prescribed Seroquel (quetiapine) 50mg twice daily. Dr Balzer said in the evidence that he increased the mirtazapine to increase the antidepressant effect and added Seroquel (which is mainly an antipsychotic) to overlap by helping with agitation and also SB's poor sleep.

48. On 24 February 2017, an entry was made in the clinical records by Acting Nurse Unit Manager (NUM) Balagtas. It recorded SB was seen in the main clinic NUM's office that morning to discuss his current health care needs. SB said that he was having "deep depression and anxiety" and said that he was unsure whether the current medication was working. RN Balagtas followed up with the psychology department who said that he was on the priority one list for follow up.

49. On 25 February 2017, SB completed another 'Patient Self Referral Form'. On this occasion he requested to see a psychiatrist regarding his "mental stability". He referred to difficulties in coping.

50. On 27 February 2017, RN Balagtas received an e-mail response from the GEO Group Psychologist Team Leader, Dr Lutchman, noting that SB was due for a follow up "soon".

51. SB made a further request to Justice Health on 1 March in relation to his mirtazapine (Avanza) being supervised. SB noted that this meant that he had to take it early and that he would wake up at 4am when his depression and anxiety was worst and would not be able to go back to sleep.

52. On 6 March SB's brother called Parklea and said that he feared for his brother's life. He was critical of the clinic and said that SB was suffering from sleep disorders (possible from medication), panic attacks and claustrophobia.

These concerns were referred to the area manager and psychology.

53. On 7 March 2017, SB did not attend an appointment with the clinic to see a general practitioner. It is documented in PAS that the reason why SB did not attend was 'C7 cancelled by DCS', indicates that the appointment was cancelled by the Department of Corrective Services (in this case – GEO).

54. On 7 March 2017, SB was seen by a psychologist, Mr Matthew Pietersen. A case note by the psychologist that SB presented as moderately distressed. SB told Mr Pietersen that his medication was mildly effective, and raised a medication review. He also reported frequent panic attacks when first waking. The note recorded that SB denied thoughts, plans or intentions to harm self or others, and that "previously had fleeting thoughts of suicide however acknowledged family (children) as strong protective factor".

55. The inquest heard that on this date, SB disclosed to Mr Pietersen that he had experienced suicidal ideation as recently as that morning. This fact was not recorded in the Offender Integrated Management System (OIMS). Mr Pietersen gave evidence that he found this suicidal ideation to have not been 'intensive' and noted his use of the word 'fleeting' in his case note in this regard. Mr Pietersen said that from the notes, he believed that the suicidal ideation was a one off.

56. The following day, at Mr Pietersen's request, Ms Yu sent an email to Justice Health nursing staff advising that SB was requesting a medication review.

57. On 9 March 2017, CNC Ford made an appointment for SB to be reviewed by a psychiatrist. CNC Ford had no specific recollection of the circumstances leading to him booking the assessment with a psychiatrist, but observed that contact had again been made with the mental health line.

58. On 14 March 2017, SB was seen by another Justice Health GP, who made an entry in the clinical records that Avanza and Seroquel were "helping somewhat", and that SB was for review by the mental health team.

59. SB was seen again by Mr Pietersen the psychologist on 15 March 2017. He again presented as moderately distressed. An assessment administered by Mr

Pietersen on this day recorded that SB agreed with the statement "I have thoughts of killing myself, but I would not carry them out". SB was to be further followed up by psychology. In evidence Mr Pietersen said that he would discuss such a response if it was new information, but noted that the criteria for the question was how the person has been feeling for the preceding two weeks (which included the time of the previous assessment).

60. On 20 March 2017, SB was seen by Dr Malik, a Justice Health psychiatrist. The clinical notes record "Denies suicidal thoughts", and that SB said "if I didn't have kids I would have. I'd never do it with kids, it just passes on the pain to them." Dr Malik diagnosed anxiety/adjustment disorder and prescribed Venlafaxine 75mg (also known under the brand name Effexor) in addition to the medications already being taken by SB.

61. In evidence Dr Malik said that he had no basis to place SB on a green card at the time he saw him. Dr Malik said that he had no access to the psychologist's assessments, and agreed that it would have been useful to know the results of those, particularly any reference to suicidal ideation.

62. On 23 March 2017, CNC Ford sent an email to RN Osborne asking that she make new waiting list entries for all patients who had been seen by psychiatrists whilst CNC Ford was on leave; this included SB. On 23 March 2017, RN Osborne replied to CNC Ford's email and informed him that she had arranged for SB to be reviewed by a general practitioner.

63. On 30 March 2017, SB was visited at Parklea by his solicitor, Mr Craig Lynch. This seems to have been a difficult meeting and to have involved some significant discussion regarding the prosecution brief and the strength of the evidence against SB, as well as a forthcoming Supreme Court bail application. Mr Lynch later recalled that SB said that that "he previously thought of committing suicide but would not and could not do it". SB told Mr Lynch that he had not spoken with psychologist because otherwise he would get put in a padded cell. SB said that this was what other inmates said. Mr Lynch was so concerned that he contacted SB's mother after the visit and told her of his concern.

64. Later on 30 March 2017, SB's mother called Parklea and spoke with Ms Yu. Ms Yu's note records concern for SB's well-being on the part of SB's mother, but that she was "vague" about his risk of self-harm. It goes on to record "She insisted for her son to be monitored and reported that he would be best to be housed with someone, i.e. not in safe cell". Ms Yu agreed to assess SB. In evidence, Ms Yu could not recollect the words used, but agreed that she and Mr Pietersen were concerned and went to assess him.

65. A case note recorded by Mr Pietersen noted that SB was seen at his cell door after lock-in by both Mr Pietersen and Ms Yu. SB reported having disclosed some situational stress and coping concerns to his immediate family at a visit that day, particularly regarding upcoming Court stressors. SB denied thoughts, plans or intentions of harm to himself or others and again acknowledged his family as a strong protective factor. SB guaranteed his safety and repeatedly confirmed he was not at risk of harm and that he would notify staff if needed. SB declined the offer of a further psychological appointment on 31 March 2017, and agreed to self-refer if necessary. The plan was for SB to remain on PSYCH1 line for follow up.

66. Ms Yu told the inquest that both her and Mr Pietersen agreed that SB was low risk, and that if either of them considered differently, they would have initiated the Risk Intervention Team ("RIT") process. This would have necessitated the involvement of Justice Health. Ms Yu said that it was her understanding that in order for green card status to be activated, the RIT process was required (which involved a period in an assessment cell).

67. Mr Pietersen in his evidence agreed that SB was assessed as low risk, and said that had he been assessed higher (as moderate risk), he would have taken steps to place SB on a green card.

68. During 31 March and 1 April SB made a number of calls to his mother, father and sister.

2 and 3 April 2017

69. At 0843 hours on 2 April 2017, SB's cellmate, TM was taken from the shared

cell and temporarily transferred from Parklea for a court appearance in Newcastle.

70. At 0919 hours on 2 April 2017, SB telephoned his solicitor Mr Lynch. He provided brief instructions regarding his case. Mr Lynch later said that SB did not sound anxious and that he did not highlight any concerns.

71. Later in the day, was visited by his mother and father. According to his father, SB was very agitated and depressed as his case was moving very slowly and his bail application had been moved back to May. SB was reportedly concerned that even if he got bail, he would still not be able to see or talk to his family (partner and children) due to the terms of an AVO that was in force. His father later said that it appeared to him that the medication that SB was receiving made things worse, and that his mental health continued to decline.

72. Shortly after 3:20pm the muster of inmates was completed and they were locked in. At 5:42pm a medication round was conducted and SB received his medication from a Justice Health nurse. Security checks of the cells were later conducted during the evening and night on several occasions, albeit this did not involve any sighting of SB. SB was alone in his cell.

73. Shortly after 8am on 3 April 2017 a group of prison sweepers were tasked with delivering milk to the cells. At 8:07am, one came to SB's cell. He could not see through the Perspex window in the door. A second sweeper came over. They called out to SB. The sweepers called for the assistance of officers, two of whom were at the cell door within a minute. On opening the door the officers immediately saw SB hanging in the doorway. The officers activated what is known as a CERT 1 alert and worked together to cut SB down. The prison sweepers also assisted. The officers then started chest compressions and called for an ambulance.

74. Further officers arrived and provided assistance. Within 5 minutes, a nurse from Justice Health arrived with a defibrillator. The nurse took over CPR. Further Justice Health nurses arrived, and an airway bag was used. Ambulance paramedics arrived approximately 10 minutes after the arrival of

the Justice Health nurses and took over CPR.

75. Ambulance records indicate that they arrived at SB's cell at approximately 8:28am, and that SB was in asystole throughout their time treating him. The paramedics administered adrenaline with no effect. At 8:47am the senior paramedic declared SB to be deceased.

76. SB's body was later taken to Royal Prince Alfred Hospital, arriving at 2:55pm. A certificate of life extinct was issued.

77. A report was obtained by the family from an emergency physician, Professor Gordian Fulde, regarding the resuscitation attempts. That report was provided to those assisting me, and was included in the brief. Professor Fulde considered that the CPR administered was appropriate.

78. Forensic examination of the scene identified that SB had used a bed sheet and towel to hang himself. SB's body was observed to still have the ligature around his neck. The towel and sheet had been tied to the lowest of three ventilation flaps above the door. A chair appeared to have been used and kicked away.

79. The note later located in SB's cell was addressed to his family. It referred to his love for them, and his appreciation of the support that they had provided to him whilst he was in custody. It included the statement, "The pain of being in here and not seeing my family is too much."

Autopsy Report and Toxicology:

80. A limited autopsy was conducted on 5 April 2017 by Dr Rebecca Irvine of the Department of Forensic Medicine. Dr Irvine identified the direct cause of death as hanging. She did not identify any suspicious findings, or any findings inconsistent with the history provided to her. In her report she also noted the toxicological findings, which included the medications prescribed to SB.

81. Forensic Toxicologist, Professor Alison Jones found that Venlafaxine was in SB's blood at a level that was inconsistent with having taken the drug in a

manner consistent with what was prescribed to him. The inquest heard from Professor Jones that this could wholly be explained by the rate of SB's metabolism. Similarly, Mirtazapine was in SB's blood at a level that inconsistent with having taken the drug in the manner prescribed to him. Professor Jones opined that issues relating SB's metabolism could only partially explain this.

82. This leaves open the possibility that SB was hoarding his medication and took an excessive dose. However, the evidence was that SB received his medications in a supervised fashion, and it was the evidence of his cellmate, TM, that he never saw SB take any steps to hoard medication. Ultimately, I am unable to resolve this issue.

83. In her report, Professor Jones raised the theoretical possibility that the levels of mirtazapine (along with the venlafaxine) in SB's blood may have had an effect on SB's neurotransmitters and thereby changed his behaviours. She noted some literature pointing to the potential for increased feelings of anxiety, panic and impulsivity as a result of mirtazapine. Professor Jones qualified this significantly, noting that the evidence regarding this is conflicting. She also noted that some drugs take some time to have an effect.

Issues explored at the inquest

84. I will now consider the issues identified in the list of issues as circulated prior to the inquest.

Issue 1: Adequacy of care and treatment provided at Parklea

85. The first issue concerns the psychiatric and psychological care and/or treatment provided to SB by Justice Health, CSNSW and/or GEO Group at Parklea Correctional Centre in 2016 and the adequacy and appropriateness of that care and/or treatment.

86. During the coronial investigation, medical records from Justice Health, GEO and Corrective Services were obtained and statements of doctors, nurses, psychologists and psychiatrists involved in SB's care at PCC were obtained.

Policy documents from Justice Health, Corrective Services and GEO that were in place at the time of SB's death and subsequently also formed part of the brief of evidence.

87. Corrective Services NSW were not directly responsible for providing either psychiatric or psychological care to SB.

88. Psychological care was provided to SB by psychologists at GEO. GEO psychologist Matthew Pietersen was responsible for the area in which SB was housed, assisted by Cathy Yu, who was not sure whether she was a provisionally registered psychologist or registered psychologist at the time. Both gave evidence at this inquest.

89. Psychiatric care was provided to SB by psychiatrists at Justice Health. SB was seen on one occasion by Dr Malik, a consultant forensic psychiatrist who at the time was employed by Justice Health. Dr Malik gave evidence.

90. Dr Sarah-Jane Spencer, a consultant forensic psychiatrist and the current Clinical Director, Custodial Mental Health and Co-Director (Clinical Services) for Justice Health gave evidence. Dr Spencer considered the therapeutic regime implemented by Dr Balzer and Dr Malik to be appropriate. In her opinion the use of Seroquel in combination with antidepressants was not controversial.

91. Expert forensic psychiatrist's Dr Adam Martin and Dr Olav Nielssen provided opinions in these proceedings, and gave oral evidence.

92. Dr Martin considered that the diagnosis of anxiety and adjustment disorder raised by Dr Malik (on 20 March 2017) was appropriate. He noted that adjustment disorder is described in the DSM-5 and essentially describes a reactive depression/anxiety state of clinical significance, causing impairment.

93. In his report Dr Nielssen expressed the opinion that SB had developed a severe form of depressive illness in which he felt he had no future, and that suicide was a reasonable course of action. Dr Nielssen indicated in oral evidence that adjustment disorder can be different way of describing a state of depression. He said that specific label does not alter the appropriate treatment.

94. Given the available information, Dr Martin considered it likely that SB had longstanding problems with mood with a background of alcohol use disorder and previous head injuries.

95. Dr Martin also indicated that adjustment disorders, in particular, are very common presentations for Justice Health clinicians, as people present in highly stressful circumstances, having been isolated from their family facing serious charges with associated feelings of shame.

96. When asked about adequate and appropriate care, Dr Martin said that an assessment of whether an individual receives adequate and appropriate care should be seen in the context of the overall load of clinical presentations of correctional centre inmates. From his experience and knowledge, Dr Martin opined that there is an overwhelming demand of mental health presentations among correctional centre inmates. He said that at any one time, review of most inmates' records would demonstrate multiple known risk factors for suicide. He said that, in a general sense, most inmates would present with adjustment issues and it would be very common for inmates to have a background of mood disorder, self-harm, substance use disorder, relationship dysfunction and poor coping abilities.

97. In his opinion, a person presenting as SB did would not have met criteria for referral to the Mental Health Screening Unit or treatment as an involuntary patient at Long Bay Hospital or the Forensic Hospital.

98. Dr Martin noted that SB was seen by a mental health nurse, reviewed by a general practitioner, initiated on anti-depressant treatment, which was subsequently increased, and was then referred to a psychiatrist. As indicated above, he supported the diagnosis made by Dr Malik. He noted that suicidal thoughts were asked about and follow-up was arranged. Dr Nielssen noted that staff at the Justice Health clinic (and the prison psychological services) responded promptly to referrals from SB's mother and his solicitor, and that on each occasion he was seen very soon afterwards.

99. Dr Martin considered that Dr Malik's clinical impression and management plan, while brief, was reasonable given the aforementioned context of high demand

mental health services within the correctional setting.

100. In relation to the prescription of medication, Dr Martin considered that the decision by Dr Malik to add Venlafaxine (75 mgs daily), to the already prescribed, Mirtazapine (45 mgs) and Quetiapine was reasonable. In his opinion, a combination of Mirtazapine and Venlafaxine is a well-known and reasonable combination. Both experts confirmed that mirtazapine was a first line antidepressant.

101. Similarly, Dr Nielssen said he was not critical of the medication regime employed by the doctors who saw SB. He noted that the appropriate time for a further review of SB's medication would have been shortly after his death, and that at least two weeks is required to ascertain whether a new or altered medication regime is working.

102. Dr Martin said that the addition of Venlafaxine to Mirtazapine demonstrates that Dr Malik was aware of there being a serious mood disorder requiring treatment. He said that follow-up by a general practitioner would have been reasonable and would mirror management intervention in the community where a psychiatrist would assess a person, diagnose, make management changes and would request follow-up for further general practitioner review.

103. Dr Martin also commented on the 'off-label' prescription of the antipsychotic medication Quetiapine, which Dr Nielssen had raised in his report. Dr Martin said that the prescription was not controversial and that it is common practice among clinicians in various settings, including correctional centres, as well as the community, for adjunctive low-dose Quetiapine prescription. He said this was for its anxiolytic and sedative properties when a person is presenting with distress, agitation and sleeplessness. Dr Martin said that it would not be common practice or particularly helpful for clinicians to document the rationale for specific choice of medications and the lack of documentation for explaining such a rationale would not have had any material impact in relation to SB's trajectory.

104. Dr Nielssen initially disagreed with certain limited aspects of Dr Martin's opinions about medication, however, in the course of giving concurrent

evidence in Court, their positions became more closely aligned. In evidence he was not critical of the off-label prescription of Quetiapine, but still considered that some further clinical documentation of the basis for its use would have been appropriate, although largely for the purpose of making clear the basis of the decision I retrospect.

105. The clinical notes of Dr Balzer were of exceptional brevity, lacking any level of detail. Both experts agreed that they should have been more fulsome. This was readily accepted by Dr Balzer in his evidence. There was no suggestion by either of the experts that if Dr Balzer's notes included more detail that this would have led to a different outcome.

106. On the basis of all the evidence, in particular the unanimous views of the experts and Dr Spencer, I find that the overall care and treatment of SB was appropriate. Relevant to this conclusion is the fact that none of the clinicians who saw SB had all of the information. I return to this issue later in these findings.

107. I also observe that the were some initial delays in SB receiving treatment via Justice Health. This was some months prior to SB's death, and was therefore not the focus of the inquest. However, it is to be hoped that delays in inmates receiving medical assistance will be minimised in the future, wherever possible. As outlined later in these findings, I note that the current contractual arrangements for the operation of Parklea by MTC Broadspectrum includes a key performance indicator in relation timely provision of primary health services.

108. In particular, I find that that the diagnosis and corresponding prescribing of medication was appropriate. Whilst the clinical documentation was brief, particularly in the case of Dr Balzer, in my assessment it did not materially impact the outcome.

109. In the case of Ms Yu and Mr Pietersen, they were junior clinicians at the time that they saw SB. They carried a large workload. Whilst there were further matters that could have been included in the case notes, they were generally detailed, and on the available evidence the appropriate assessments of SB

were carried out. Once commenced, the psychologists appropriately continued to follow SB up. In the case of the final psychological assessment conducted jointly by Ms Yu and Mr Pietersen on 30 March 2017, whilst it was conducted at the door of SB's cell, this seems to have been an appropriate response to the situation at hand.

Issue 2: Consideration of relevant policies in relation to mental health care and/or treatment and communication between Justice Health, CSNSW and GEO Group

110. The second issue considers the relevant policies, procedures or protocols (hereafter "policies") of Justice Health, CSNSW and/or GEO Group regarding a prisoner's mental health care and/or treatment, including policies relating to the communication between the three entities of such issues, and whether those policies were adhered to, and the adequacy or otherwise of them.

111. It is significant that neither Justice Health, CSNSW or GEO Group staff were in receipt of all of the relevant information in relation to SB.

112. It is also significant that none of SB's treaters were in receipt of information in relation to SB's mental health that was offered by TM for the first time in his oral evidence at this inquest. The inquest heard from TM that on one occasion he found SB to have dismantled a razor blade for the purposes of self-harm and that on another occasion SB spoke of wanting to hang himself, but TM talked him out of it. The inquest also heard from TM that one and a half weeks after Dr Malik reviewed and changed SB's medication on 20 March 2017, SB stated that he "wanted to end it".

113. I also observe that when SB was reviewed by both Dr Malik and Dr Balzer, neither clinician was aware that on 7 March 2017, SB had experienced suicidal ideation and had expressed this to GEO Psychologist Matthew Pietersen.

114. It was the evidence of Dr Malik that he would have been assisted by having such information and any other information regarding psychological assessments of SB to inform his psychiatric assessment of SB. Dr Spencer and the experts agreed that more information is generally of assistance, as long as it can be easily identified.

115. At the time of SB's death, no route existed to transfer information from GEO Psychologists to Justice Health. The GEO, Justice Health and Corrective Services witnesses, and the experts, all agreed that this would have been of assistance.

116. The need for an effective flow of information between the different clinicians was highlighted by the fact that had a general practitioner reviewed SB's medication as planned by Dr Malik (in the week or so after 30 March 2017), the general practitioner would not have been aware that SB had been assessed by GEO Psychologists on 30 March after hours, after concerns were raised for his mental health by family members.

117. The inquest heard that since the time of SB's death, significant changes have been made to this process. It was the evidence of Julie Ellis, Director of Operational Performance Review Branch for CSNSW that clinicians such as general practitioners, psychiatrists and mental health nurses now have access OIMS. In addition, OIMS is able to be filtered in such a way as to only include the relevant medical information required by the user.

118. I am satisfied that there has also been a change in the allocation of responsibilities at Parklea. The inquest heard from Ms Ellis that if an inmate at Parklea were to now seek after hours mental health care and/or treatment, they would be seen by a Mental Health Nurse (employed by St Vincent's) who would update OIMS. This information would therefore be available to the treating general practitioner and/or psychiatrist.

119. There has also been a significant change in the way an inmate is assessed as at risk. Approximately three weeks after SB's death, Corrective Services NSW introduced a new framework for assessing an inmate who is at risk, which is more directive than the policy in place at the time. The new policy includes a list of factors that require an 'at risk' notification to be made.

120. Given these changes, I do not consider it necessary or desirable to make any recommendation on this issue.

Issue 3: Whether the cell placement and observation of SB was appropriate and/or sufficient

121. The third issue considers whether the cell placement and observation of SB was appropriate and/or sufficient.

122. As a result of the Health Problem Notification Form completed on 25 November 2016, SB was initially placed in a 'two-out cell placement' for a period of two weeks meaning he was to share a normal cell with a selected cellmate and was not to be left alone at any time. The rationale was that it was SB's first time in custody and Justice Health were concerned that SB had the potential for alcohol withdrawal. At that time, Justice Health and GEO staff were not aware of any history of self-harm or suicidal ideation.

123. On 19 January 2017, SB was moved to Area 2C, cell 6. His cellmate from this date was TM, however, there was no requirement that he be with a cellmate at all times.

124. The issue in the inquest focussed on whether SB should have been placed on a 'green card' or 'two-out cell placement' on 30 March 2017 after being seen by the GEO psychologists. When subject to such a status, an inmate is never left alone in their cell. They are also ineligible for certain work as this requires them to be alone at times.

125. GEO Psychologist, Matthew Pietersen, stated it was within his authority to activate a green card. He had knowledge of SB's suicidal ideation as recently as 7 March 2017 during his own assessment of SB. However, his evidence was that on 30 March 2017 he assessed SB as being low risk. He said that had he assessed him as being at moderate risk he would have activated the green card procedure.

126. It was the opinion of the experts Dr Martin and Dr Nielssen that only with the benefit of hindsight, that on 30 March 2017 the psychologists could have considered the activation of a green card status, without a progression to a mandatory notification of risk and the activation of review by a Risk Intervention Team. Neither suggested that they would have necessarily done

so.

127. Dr Martin noted that SB was not presenting with current suicidal thoughts or plans, and that it would have been counter-therapeutic, for instance, for SB to have been placed in an isolation cell under camera monitoring (as would have been the case had he been subject to assessment by the Risk Intervention Team). Dr Martin noted that it seemed apparent that SB may have been down-playing his thoughts to everyone.

128. Both Dr Martin and Dr Nielssen said that it is very difficult to predict who might or might not attempt self-harm, and that the prediction of when it might occur is similarly difficult. They both said that while the risk factors were well known, these were not great predictors of which individuals will in fact take that step. Both experts also said that the risk of suicide fluctuates over time. Dr Nielssen also noted that the prison population was a high risk population, and that the suicide risk for prisoners is even greater in the year after release from custody.

129. Dr Spencer noted that Justice Health clinicians use their clinical judgement in making recommendations regarding cell placement. She said that generally they are weighing up a significant number of factors, and are balancing risk versus what the inmate may be articulating as being in their best interests.

130. A number of the clinicians and experts noted that many inmates do not like being subject to green card status, due to the additional restrictions it places on them. It was noted by Dr Spencer that the remand population in particular are resistant, as they are required to go to court a lot, meaning that those on a two out cell placement, will have to be found a new cellmate immediately, rather than await the return from court of someone they may be well settled with.

131. I am satisfied that with the benefit of hindsight, SB could have been placed on a green card but accept the evidence of the experts that it was open to SB's treaters not to have done so in the circumstances.

132. As to Dr Malik, Dr Balzer and the other Justice Health clinicians, it should be

remembered that they had no knowledge of any suicidal ideation of SB, and the most recent interaction with SB had been on 20 March 2017 when he was seen by Dr Malik. There does not appear to me to have been any clear basis on which Justice Health staff should have reached the conclusion that SB should be made the subject of a recommendation for two-out cell placement.

133. I also find that there was nothing raised on 2 or 3 April 2017 with the custodial staff that would have warranted anything other than the normal cell checks of SB's cell. These do not involve sighting the inmate.

134. I conclude that that with the evidence available to the relevant treaters at the relevant time, the cell placement and observation of SB was appropriate and/or sufficient.

Issue 4: The presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea

135. The fourth issue considers the presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea.

136. It is apparent that hanging points in the custodial environment continues to be a matter of concern. It has been a long standing issue in many prisons, and I note that other recent inquests have made findings and recommendations in this regard, including in relation to Parklea.

137. It was the evidence of Ms Ellis that all hanging points of the type used by SB have been removed at Parklea, and that there has been a review and reduction of hanging points more generally in Areas 1,2 and 3.

138. The new wing at Parklea (area 6) that opened in March of this year has made significant improvements to the overall design of the cells, and appears to significantly reduce the risk of hanging. Some older areas have been closed and are being assessed for further improvements. Those categories of inmates considered at higher risk (fresh custodies, inmates identified as at risk, and remand inmates) are now housed in the new wing.

139. I accept the evidence from Ms Ellis that a remand inmate such as SB would now be housed in this new area and that significant improvements have been

made. Given this and the relatively recent recommendations made by Deputy State Coroner Ryan in the Inquest into the death of L, I consider that it is not necessary or desirable to make any further recommendation on this issue.

Issue 5: Policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide

140. The fifth issue considers relevant policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide, including whether the requirements of those policies were met, and the adequacy or otherwise of those policies.

141. There is significant overlap between this issue and other matters already touched upon.

142. It was the evidence of the experts that the appropriate assessments were administered following concerns raised about SB's mental health and that in the months leading up to his death, these assessments were administered in a fairly timely fashion.

143. No evidence was given to the inquest from the current provider at Parklea, MTC Broadspectrum Consortium, however the inquest heard evidence from Ms Ellis that the current contractual arrangements between CSNSW and MTC Broadspectrum outline a number of Key Performance Indicators. These include serious self-harm incidents, timely provision of primary health services, chronic health care plans and health screening as well as a number of other matters.

144. I accept that no specific deficiency in the following of the relevant policies has been identified.

145. I also accept that upon review of the current contractual arrangements with MTC Broadspectrum, and the CSNSW Identification of 'at risk' inmates' policy that came into existence approximately three weeks after SB's death, that the relevant policy framework has changed very significantly since SB's death, and that no recommendation is required in relation to this issue.

Issue 6: Whether any recommendations from the Coroner are necessary or desirable, including for prisoners' health and safety

146. As I have noted, some improvements have already been implemented at Parklea. The policy in relation to identifying 'at risk' inmates was amended three weeks after SB's death, there is greater use of OIMS allowing for a more efficient flow of information between treaters, mental health care and treatment is a Key Performance Indicator for the new provider at Parklea and substantial work has been completed on the removal of hanging points.

147. In addition to the issues already considered, Dr Fulde raised the issue of tear resistant sheets and towels. This issue had also been the subject of a recommendation by Deputy State Coroner Ryan in the *Inquest into the death of L*. Having heard evidence from Ms Ellis on this issue, I am satisfied that there is nothing further that can be presently achieved in that regard.

148. Counsel Assisting ultimately submitted that it was not necessary or desirable to make any recommendation in relation to SB's death. I accept that submission.

Findings required by s.81(1) of the *Coroners Act 2009*

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

The identity of the deceased
The deceased person was SB.

Date of death
SB died between 5:52pm on 2 April 2017 and 8:07am on 3 April 2017.

Place of death
SB died in his cell at Parklea Correctional Centre, Quakers Hill NSW.

Cause of death
The death was caused by asphyxiation by ligature.

Manner of death

SB's death was intentional and self-inflicted, in circumstances where he was an inmate in Parklea Correctional Centre.

Concluding remarks

150. This matter highlights the challenge of managing the mental health of prison inmates, particularly those on remand. According to Ms Ellis the remand population has grown significantly since amendments to the *Bail Act 2013* were introduced.

151. As a group, prisoners face a large number of stressors. Remand prisoners, particularly those in custody for the first time and those facing very serious charges (as SB did) have to contend with a number of additional stressors.

152. Despite these issues being well known, prediction and prevention of suicide remain very difficult for clinicians working in that environment. One comment of Dr Martin was particularly apt; he said, "Treating mental health in prison is like treating malaria in a swamp."

153. In this case, the stress on SB must have been enormous. It was beyond the scope of this inquest to consider the strength of the charges against him. They were however very serious, and whatever their truth, would have placed a huge weight on SB's mental wellbeing in custody.

154. It is clear that SB enjoyed strong family support after his incarceration. There were a significant number of visits and phone calls, and it appears that SB relied heavily on them.

155. In closing, and on behalf of the coronial team, I offer my sincere and respectful sympathy to SB's family. I hope this inquest has answered some of their questions about his very sad death.

I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner

Date