CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of P
Hearing date:	21 October 2021
Date of findings:	21 October 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death by hanging of a person in lawful custody – frequency of medication reviews – reduction of hanging points at Long Bay Correctional Centre.
File number:	2017/121886
Representation:	Coronial Advocate assisting the inquest: Sergeant A Chytra, NSW Police. The Justice Health and Custodial Mental Health Network: N Szulgit, JH and Forensic Mental Health Network. The Commissioner, Corrective Services NSW: E Trovato, Department of Communities and Justice Legal.

Findings:	**Identity** The person who died is P. **Date of death**: P died between 22 and 23 April 2017. **Place of death**: P died at Long Bay Correctional Centre, Sydney. **Cause of death:** P died as a result of hanging. **Manner of death:** P's death was an intentional self inflicted death, while he was in lawful custody.

Non-publication orders

The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009.*

The Court has also made an order pursuant to section 75 of the *Coroners Act 2009*, that evidence shall not be published which discloses the identity of the deceased person. In these findings the deceased person is referred to as 'P'.

Details of these orders can be found on the Registry file.

1. Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of P.

Introduction

3. P was aged 72 years when he died at Long Bay Correctional Centre, at some time between 22 and 23 April 2017.

4. P had been in custody since 11 October 2011. In 2012 he was sentenced to a term of imprisonment of nine years. He would be eligible to seek parole on 10 October 2017. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

5. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

6. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

7. P was born in Sydney on 17 July 1944. As an adult he worked as a computer technician, before retiring from paid work. He then taught computer skills on a voluntary basis. He was divorced from his second wife, and he did not have contact with his four adult children.

8. On 11 October 2011 P was convicted of child sexual assault offences. He was taken into custody to await sentencing. On entering custody, he disclosed a history of depression and hypertension, for both of which he used prescribed medication. These medications were continued while he was in custody.

P's treatment for depression

9. During his time in custody P's mental health was reviewed by psychiatrists and mental health nurses. A psychiatric assessment on 24 July 2012 resulted in an increase to his medication sertraline. This was changed to desvenlafaxine as a result of a psychiatric review on 31 October 2013. During this assessment P disclosed for the first time that he had attempted to overdose on his hypertension medication. His risk of suicide was assessed

as medium to high, and he was assessed daily until 14 November 2013. By this time, it was considered his risk had abated, but that he would require a 'two out' cell placement to mitigate his risk, meaning that he was required to share a cell with another inmate. This arrangement continued until July 2014, when he was considered suitable for normal cell placement.

10. In a mental health review on 9 September 2016, P disclosed that he was not tolerating his desvenlafaxine medication. He was reviewed by a psychiatrist the following week, and his medication was replaced with the antidepressant mirtazapine. P denied having any thoughts of harming himself or others.

11. P's dosage of mirtazapine was increased as a result of a mental health review on 3 November 2016. Registered Nurse Philomena Twomey, who conducted the assessment, spoke by phone with the on call psychiatric registrar who approved the dosage increase.

The further charges

12. On 14 March 2017 P was charged with further offences. He was refused bail for the new charges, meaning that it was unlikely he would be released to parole later that year as he had anticipated.

13. On 28 March 2017 P had another mental health review with RN Twomey. He told her he was feeling stressed and worried about the new charges, but that he was not having thoughts of self-harming or suicide. He rated his mood as at a level similar to that which it had been throughout most of his incarceration. However, he told RN Twomey that he didn't think his medication was as effective as it had been previously.

14. RN Twomey discussed with P a plan of increasing his mirtazapine and having a follow up mental health review in two to three weeks' time. Her overall impression was that his mood had deteriorated as a result of the new charges, but that he did not intend to harm himself. RN Twomey spoke by phone with the consultant psychiatrist and obtained approval for the medication increase. This dosage commenced on 29 March 2017.

The events of 22 and 23 April 2017

15. On the evening of 22 April 2017 P had a physical altercation with his cellmate. During the incident P said: '*I'm going to die in here, I've got another ten years to serve … If I'm going to die in here I'm going to kill you'*. P then struck his cellmate several times with the cellmate's walking stick. The fight came to an end when the cellmate managed to alert correctional staff.

16. P was taken to the medical clinic and treated by RN Jessica McLoughlan for some minor cuts and abrasions. He told her he had no thoughts of self-harm, saying: '*As long as I'm not with [the cellmate] I'll be fine'.* RN McLoughlan noted P had an appointment for a mental health review the following week. She arranged for him to have a medical review the next day.

17. P was then returned to his cell, which he was to occupy alone to avoid any further altercations. There was no current requirement for him to be accommodated with a cellmate.

18. The next morning at 7.17am a correctional officer opened the door to P's cell. P was hanging by his neck with a ligature made from bed sheets. This had been tied to the bars of the window. The correctional officer immediately called for help and P was cut down. Resuscitation efforts commenced straight away and were continued when Justice Health nurses arrived. However, P could not be revived, and he was pronounced deceased at 7.43am.

The cause and manner of P's death

19. An autopsy performed by pathologist Dr Elsie Berger confirmed that P had died as a result of hanging. There is no evidence that anyone else was involved in P's death.

20. The evidence supports the further finding, that the manner of P's death was self-inflicted and intentional.

Mental health reviews

21. In the course of this coronial investigation, inquiries were made as to the practice within the JH Network of adjusting patients' medication without a face to face review by a psychiatrist. In P's case, as can be seen from the above, his mirtazapine medication was adjusted on 3 November 2016 and again on 28 March 2017. On both occasions this occurred without P being assessed in person by a psychiatrist. Instead, the mental health nurse discussed P's case on the phone with the on call psychiatrist. It is noted that the model of health care provided to inmates by the JH Network largely involves nursing staff '*consulting with remotely based specialty medical staff for advice'.*

22. An internal review into the circumstances of P's death did not find any deficiencies in his care and treatment for his mental health issues. However, the review identified two ways in which access to care could be improved for inmates like P.

23. The first was that there be a review into the adequacy of resourcing for mental health nurse positions. The court heard that this review was conducted and that as a result, at Long Bay Correctional Centre there was an increase in such positions, from 1.6 to 2 fulltime positions.

24. The second proposal was that clear guidelines be developed, including timeframes, for when there should be a face to face medical review of patients who have medication increases.

25. This proposal led to the development within the JH Network of *Guidelines for Psychotropic Medications 2020.* This document notes that '*best practice for patients on long term medications [is] to be reviewed by a clinician or mental*

health nurse who can discuss with the prescriber every six months'.
Medication could be adjusted without a clinical review provided that:

- the patient has been compliant with their current medication
- the change is considered clinically appropriate and safe
- the patient has been seen within the previous six months by a psychiatrist, GP or mental health nurse and
- any required metabolic monitoring is ordered.

26. The practitioner must however request that the patient is booked for a face to face review of medications within the next six months.

27. With regard to this issue, the court was assisted with a report from forensic psychiatrist Dr Danny Sullivan dated 31 December 2020. Dr Sullivan's opinion was sought as to whether the development of such guidelines for medication review would be beneficial within the custodial setting.

28. In Dr Sullivan's opinion the above Guidelines set appropriate standards and timeframes for review, having regard to *'community standards and the realities of medical practice in correctional settings'.* Dr Sullivan noted the potential for adverse effects and abuse of prescription medications, and added that '*a safe and effective system that was equivalent to the community standard'* would ensure that:

- at any time an inmate could initiate a process for urgent review
- clinical staff informally reviewed the inmate at least monthly (eg when dispensing medication)
- the prescriber or another prescriber reviewed the inmate face to face at least every six months.

29. The evidence at inquest established that P's mental health care and treatment generally conformed with the *Guidelines for Psychotropic Medications 2020,* which I note were yet to be developed at the time of P's death. P's last face to face medical review for his mental health occurred on 15 September 2016. Following that he had three reviews with a mental health nurse. On the second and third of these, his medication was adjusted after the mental health nurse discussed his condition by phone with the on call psychiatrist.

30. Compliance with the *Guidelines for Psychotropic Medications 2020* would however have meant that when P's medication was adjusted on 3 November 2016, he would have been booked for a face to face review with a prescriber within the following six months.

31. The development of the *Guidelines for Psychotropic Medications 2020* is welcome. I observe however that within the document, the concern is expressed that it will not always be possible to comply with the six month timeframe for a face to face medical review, '*due to high demand and low resources in custody'.*

The issue of hanging points

32. The second issue for examination was the perennial one of suicide mitigation within prisons. This is, tragically, a recurrent issue in NSW inquests due to

the numbers of inmates who take their own lives while in custody. Expert witnesses have repeatedly told courts that the most effective way of reducing the risk of suicide in prisons is by removing access to hanging points in cells. Recent examples include *Inquest into the death of A*, 22 October 2021, DSC Ryan; and *Inquest into the death of Tane Chatfield,* 26 August 2020, Grahame DSC.

33. In the current inquest, information was sought from Corrective Services NSW as to what steps had been taken to reduce suicide risks in Long Bay Correctional Centre. Assistant Commissioner Leon Taylor provided a statement confirming that the cells located in P's former wing have now been refurbished to remove obvious hanging points. The work included removal of cell furniture, toilets, electrical fittings and window screens, and their replacement with safer anti ligature designs.

34. This is welcome news and evidences a commitment on the part of Corrective Services NSW to address this serious issue. I encourage the Acting Commissioner to maintain this commitment, to ensure that all cells in prisons throughout NSW conform to similar safety standards.

Conclusion

35. The evidence at inquest established that the medical care and treatment which P received while he was an inmate was appropriate. The evidence did not disclose any basis for making recommendations.

36. I express to P's family my sincere sympathy for their loss.

37. I thank Coronial Advocate Sergeant Amanda Chytra for her assistance in the preparation and conduct of this inquest. I thank also the Officer in Charge of the coronial investigation, Detective Sergeant Joshua Palmer for his preparation of the brief of evidence.

<u>Findings required by s81(1)</u>

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.

Identity
The person who died is P.

Date of death:
P died between 22 and 23 April 2017.

Place of death:
P died at Long Bay Correctional Centre, Sydney.

Cause of death:

P died as a result of hanging.

Manner of death:
P's death was an intentional self-inflicted death, while he was in lawful custody.

38. I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

21 October 2021