CORONERS COURT NEW SOUTH WALES

Inquest:	Inquest into the death of GL
Hearing dates:	24 October 2022
Date of findings:	24 October 2022
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-death in custody, cause and manner of death, intentionally self-inflicted
File number:	2022/00106226
Representation:	Mr T O'Donnell, Coronial Advocate Assisting the Coroner Mr Musico for the Commissioner of Corrective Services NSW Mr Norris for Justice Health & Forensic Mental Health Network

NOTE: PURSUANT TO S 75 OF THE CORONERS ACT 2009 I DIRECT THAT THERE BE NO PUBLICATION OF ANY MATERIAL THAT IDENTIFIES THE DECEASED PERSON OR HIS FAMILY

Findings:	**Identity** The person who died was GL **Date of death** GL died on 12 April 2022 **Place of death** GL died at the Medical Services Unit at Long Bay Correctional Centre, Malabar, NSW. **Cause of death** The cause of GL's death was neck compression due to hanging. **Manner of death** The manner of GL's death was intentionally self-inflicted.
Non-publication orders:	Non-publication orders dated 24 October 2022 are attached to the court file

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of GL who died on 12 April 2022 while he was in custody at Long Bay Correctional Centre.

2. Section 23 of the *Coroners Act 2009* requires a senior coroner to conduct an inquest in cases where a person dies in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

3. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

    i. the identity of the deceased.

    ii. the date and place of the person's death.

    iii. the physical or medical cause of death; and

    iv. the manner of death, in other words, the circumstances surrounding the death.

4. This Inquest has been an examination of the circumstances around GL's death and pursuant to s.37 of the *Coroners Act 2009* a summary of the details of this case will be reported to Parliament.

GL

5. GL was born on the 13th of December 1952 in Beijing. He worked in office administration. He was married and had one daughter. In 2006 his daughter moved

to Sydney. GL and his wife first visited their daughter in Sydney in 2013 and then visited a couple of times of year. In 2018 after he retired, GL and his wife applied for a parenting visitor visa to move to Australia and were living with his daughter in Sydney at the time of his incarceration

Incarceration

6. On 21st of September 2022 GL strangled his wife with an electrical cord. He then drove into a wall in an attempt to inflict his own death. He sustained serious injuries that rendered him a paraplegic and was taken to Liverpool Hospital. He was formally charged with the murder of his wife on the 11th of November 2020 and bail refused.

7. He was initially taken into custody at the Spinal Rehabilitation Unit of Prince of Wales Hospital. He had acquired spinal cord ischemia in the accident and had an insertion of an indwelling catheter and stoma formation.

8. On 1 July 2021, he was transferred into the Medical Services Unit of Long Bay Correctional Centre. He communicated with medical staff with the assistance of a mandarin interpreter. He had regular medical appointments throughout 2021. On 26 July 2021 he was re-admitted to the Spinal Rehabilitation Unit for three weeks due to decreased weight, lethargy, and possible anorexia.

9. Upon his return to Long Bay Hospital his weight loss continued, and he was noted to be suffering from night terrors. He was referred to the Specialised Mental Health Service for Older Persons on 13 October 2021. He was reviewed on 9 November 2021. GL declined to talk about his feelings and answer any questions at the review. A further review took place on 23 November 2021 and referral was made to Transcultural Mental Health for a mental health and risk assessment. On 3 December, the Transcultural Mental Health Team reviewed GL. He reported chronic headaches and tinnitus since his motor vehicle accident. He reported having no memory of the accident and he also found it hard to hear due to noises in his ears.

10. GL was further reviewed by the specialised mental health service on; 10 December 2021, 8 February 2022 and 21 February 2022. On all these occasions he denied thoughts of self-harm but expressed that he missed his wife and was it a lot of pain due to a stoma.

11. GL was reviewed daily by registered nurses at Long Bay Hospital and received regular reviews by a dietitian and medical officer. At the time of his death, he was in cell 16 with one other person.

12 April 2022

12. At 7:40 AM on 12 April 2022 Correctives Officers were conducting the routine delivery of breakfast to the inmates. They attended GL's cell and upon entering noticed that GL was blue in the face and had a sheet wrapped around his neck. The Corrective Officers immediately notified the nurses station, and an emergency response was initiated. GL was unresponsive and unconscious with no signs of life. He was pronounced deceased at 7:45 AM.

13. Police attended the scene and interviewed the correctives officers and the nursing staff. Police also spoke with GL's cellmate. He did not recall seeing GL. He had severe physical and mental impairment and was unable to move unassisted. Police are of the opinion there were no suspicious circumstances.

14. An autopsy was conducted, and the direct cause of death was determined to be neck compression due to hanging. Paraplegia was noted as another significant condition.

15. Police believe GL used the base of his bed as an anchor point and tied a torn sheet to the right-hand side of the bottom section of the bed, wrapped it around his neck then attached the other point to the top left-hand side of the bed. He then used the electronic bed remote and activated it's "raise setting" to create a mechanical tension on the bed sheet around his neck, causing him to asphyxiate. The remote

was located under the right side of GL. It is believed he positioned the remote under his body to keep the raised setting activated and maintain the tension on the sheet.

16. GL's daughter provided a statement. She last spoke to her father on about 7 April 2022. He did not indicate to her any concerns in relation to depression.

17. On behalf of the NSW State Coroner's Court, I extend my sincere and respectful condolences to GL's daughter for her loss in these tragic circumstances.

Findings: s 81 Coroners Act 2009

Identity

The person who died was GL.

Date of death

GL died on 12 April 2022.

Place of death

GL died at the Medical Services Unit Long Bay Correctional Centre, NSW.

Cause of death

The cause of GL's death was neck compression due to hanging.

Manner of death

The manner of GL's death was intentionally self-inflicted.

Magistrate C Forbes

Deputy State Coroner

24 October 2022

New South Wales State Coroner's Court, Lidcombe