CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kerry-Ellen (Nikki) Knight
Hearing dates:	4-7 April 2022,19 May 2022
Date of findings:	28 September 2022
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; presence of hanging points in cells; COVID-19 quarantine; access to telephones; mental health and peer support programs; Reception Screening Assessment (RSA): knock ups; Patient Self Referral Form (PSRF); self-inflicted death
File Number:	2021/64779

Representation:	Counsel assisting: Dr Peggy Dwyer, instructed by Ellyse McGee, Crown Solicitor's Office Family: David Evenden, Legal Aid NSW Commissioner for Corrective Services NSW: Anne-Marie Mannile, Department of Communities and Justice Justice Health & Forensic Mental Health Network: Ben Bradley, instructed by Kate Hinchcliffe, Makinson d'Apice Nurse Monica Nguyen: Patricia Robertson, NSW Nurses and Midwives Association Nurse Nyarai Mudzingwa: Neale Dawson, New Law
Non publication orders:	Non-publication orders made on 11 August 2021, 4 February 2022, 1 April 2022, 4 April 2022 and 19 May 2022 prohibit the publication of various persons' personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was Kerry-Ellen (Nikki) Knight. **Date of death** She died on 5 March 2021 **Place of death** She died at Silverwater Women's Correctional Centre, Silverwater NSW **Cause of death**

	She died from hanging **Manner of death** Kerry was alone and locked in her cell when she placed a sheet around her neck and attached it to a shower rail, which was a prominent hanging point in her cell. Kerry had only been in custody for a short period and was subject to COVID-19 quarantine protocols. Her death was intentionally self-inflicted.

Table of Contents

Introduction

1. This inquest concerns the death of Kerry-Ellen Knight, known to her family as Nikki.

2. Kerry was born on 20 July 1976 in Dubbo. She was only 44 years of age when she died at Silverwater Women's Correctional Centre (**SWCC**) on 5 March 2021. At the time of her death she had only been in custody at SWCC for six days, and was subject to restrictions pursuant to quarantine protocols associated with the COVID-19 pandemic.

3. Kerry's sister told the court that she and Kerry were very close as children, living in many towns in rural NSW. They grew up abseiling, caving and canoeing.[1]

4. Sadly, Kerry experienced significant trauma during her childhood, and as a consequence she later struggled with drugs, alcohol and her mental health. She spent time in custody as a juvenile and as an adult.

5. Kerry's sister recalled that Kerry inspired others in her life, she was funny, quirky and had the ability to attract great loyalty.[2] One of Kerry's friends in custody described Kerry as a beautiful, friendly and caring person.

6. Kerry left behind two loving children, ZC and DK, and grandchildren. Kerry's sister and children engaged with the inquest process and it was clear that her death has caused enormous grief and profound sadness. I offer them my sincere condolences.

The role of the coroner and the scope of the inquest

7. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[3] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[4]

8. It should be noted that when a person dies in custody it is mandatory that an inquest is held.[5] The inquest must be conducted by a senior coroner.[6] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care

[1] 19.5.22 T58.41- 59.1.
[2] 19.5.22 T60.35-40.
[3] Section 81 *Coroners Act 2009* (NSW).
[4] Section 82 *Coroners Act 2009* (NSW).
[5] Section 27 *Coroners Act* 2009 (NSW).
[6] Section 24 *Coroners Act* 2009 (NSW).

they are offered is of an appropriate standard and is culturally appropriate. It is important that risk is well managed in the custodial setting where inmates have so little control over their lives and surroundings.

The evidence

9. The court took evidence over five hearing days. The court also received extensive documentary material in six volumes. This material included witness statements, medical records and expert reports. The court heard oral evidence from correctional officers, nurses and fellow inmates who had contact with Kerry in the days before her death. Dr Sarah-Jane Spencer, Clinical Director Custodial Mental Health, Justice Health & Forensic Mental Health Network (**JHFMHN**) and Therese Sheehan, Deputy Director of Nursing and Midwifery, JHFMHN both gave evidence. Expert oral evidence was also received from Dr Danny Sullivan, an independent forensic psychiatrist. The court also had the benefit of an expert report from psychologist Vanessa Edwige.

10. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

11. A list of issues was prepared before the proceedings commenced. These issues guided the investigation on the following topics:

    1. The intake assessment conducted by the Justice Health and Forensic Mental Health Network upon Kerry's reception at Silverwater Women's Correctional Centre and in particular:
        a. The assessment conducted by Justice Health Nurse Guo, and her decision not to refer Kerry for mental health follow up.
    2. Was there an appropriate response to the patient self-referral form completed by Kerry on 3 March 2021, requesting mental health assistance?
    3. Should there be any changes to the process/system of response to requests for non-urgent mental health referral?
    4. The response to the medical issues reported by Kerry in 'knock up' calls on 4 and 5 March 2021.
    5. The existence of hanging points in cells in Block F of Silverwater Women's Correctional Centre.

Background

12. Kerry-Ellen Knight (known to her family as Nikki) was born on 20 July 1976. Throughout her childhood she lived with her family in various NSW towns including Griffith, Narromine,

Purlewaugh, Grose Vale and Quirindi. Her family enjoyed outdoor activities such as abseiling and rock climbing. Kerry was described as bubbly, outgoing and extremely smart.[7]

13. When Kerry was around ten years of age she was the victim of sexual abuse for the first time. Charges were never laid but these events caused longstanding trauma and pain. Kerry's sister was able to identify how Kerry's life changed course after this event. Within a few years Kerry had dropped out of school, was experimenting with drugs and had contact with the criminal justice system. The effects of this childhood trauma stayed with Kerry throughout her life.

14. Kerry's family dynamic was complex. I note that after her parents separated, Kerry and her sister lived with different parents. At the time of her death Kerry was estranged from her mother. There is also some doubt about Kerry's exact origins. While I note that submissions received from NSW Corrective Services (**NSWCS**) indicate that it does not accept that Kerry was indigenous[8], it is very clear that at times Kerry identified as a First Nations woman. It may be that her biological father was indigenous, although that was not confirmed in evidence before this court. In any event the lack of certainty about her origins and identity is likely to have been a further source of pain for Kerry. I note that while at times she had, Kerry did not identify as indigenous during the induction process on her last entry into custody. It appears clear that identity for Kerry was complex and that her particular family situation meant that she did not always have access to the healing power of indigenous culture.[9]

15. Kerry's sister and her children ZC and DK remained important in Kerry's life, even when her path was chaotic and difficult. The court was grateful for their contribution to the inquest.

Circumstances leading up to Kerry's incarceration

16. In the period just prior to Kerry's incarceration she had been experiencing considerable difficulties and disruptions.

17. Between 4 March 2020 and 26 June 2020 Kerry had been incarcerated for various shoplifting offences. She was released on bail to Miruma Cottage, a residential diversionary program in Cessnock. She was discharged early from that program and received a Community Corrections Order.

18. In late 2020 or early 2021 it appears that Kerry commenced a close relationship of some kind with a teenage male. On 11 February 2021 a report was made to Newcastle Police alleging that the relationship was unlawful. The contact between them ended soon

[7] Vol 1 Tab 34 at [7] – [8].
[8] NSWCS Submissions at [55].
[9] The report of Vanessa Edwige provides considerable insight into how these identity issues and how her childhood trauma may have affected Kerry.

afterwards. It appears the boy's family were extremely angry with Kerry and Kerry was in turn devastated by the end of the relationship. There is evidence of distressing taunts and threats directed at Kerry by text and posted on social media platforms.

19. On 15 February 2021 Kerry called her sister and was extremely upset. She indicated that the teenage boy had been removed from her house by his family and that his family members had stolen from her and made serious threats against her. Further contact on 23 February 2021 indicated that Kerry was in somewhat better spirits. However, as the days went by Kerry began posting suicidal and distressed comments on Facebook.

20. On 26 February 2021 Newcastle Detectives were informed that Kerry had dropped off a bag belonging to the boy. Amongst his belongings was a note written by Kerry. She wrote "*It was so easy to forget you were only 15*" and "*I've been accused of grooming you, taking advantage of you, preying on you when you were vulnerable*".[10] It is not necessary for this court to determine the exact nature of their relationship, however it is clear that the boy's family believed that Kerry's conduct had been criminal and that they had taken the allegation to NSW Police.

21. On 26 February 2021 Kerry faced court in relation to three outstanding warrants for driving whilst disqualified, a police pursuit and shoplifting. She was returned to custody and transferred to Kariong Intake and Transit Centre. There is little doubt that at the time she entered custody her the lack of contact with the teenage boy and the possibility of further police action in relation to this situation would have been playing on her mind.

Reception and Screening at Silverwater on 28 February 2021

22. On 28 February 2021 Kerry was transferred to Silverwater Women's Correctional Centre from Kariong Intake and Transit Centre. She was housed in the Induction Unit and then moved to F Wing under COVID-19 Quarantine Protocols, which required all fresh custody inmates, who did not present with any COVID-19 symptoms, be quarantined from other inmates for 14 days.[11] The policy at that time required groups of prisoners entering custody on a particular day to be grouped together as a cohort and isolated from other groups also in quarantine. The court acknowledges the difficulties for inmates and staff caused by the COVID-19 protocols that were necessary at that time.

23. Kerry completed an Intake Screening Questionnaire with Joshua Evans, a Services and Programs Officer (**SAPO**). He recorded her as "*cooperative, polite, presented as talkative/reactive/upbeat at times, stated mood "flat", neat and tidy appearance, minimised*

[10] Vol 1 Tab 7 at [100]; Vol 6 Tab 87.
[11] Vol 1 Tab 44 at [3], [56], [58] and elsewhere.

charges, appropriate answers given, future oriented."[12] She also advised that she suffered from anxiety, depression and PTSD, which were all untreated. When asked if she felt there was hope for the future, Kerry answered "*there could be*". Kerry stated that she had no current plans to self-harm but that she had over the last five years.

24. Between 3 and 4 pm that day Kerry completed a physical check and interview questionnaire with a Justice Health and Forensic Mental Health Network (**JHFMHN**) nurse. Nurse Yang Guo administered the standard Reception Screening Assessment (**RSA**) tool.[13] The court heard and accepts that a screening of this nature is not intended to be a comprehensive assessment of a presenting patient, but rather a process whereby JHFMHN can promptly identify key health needs and risks that may require further assessment and intervention. Given the competing needs of the cohort, an efficient method of prioritising and triaging need and prioritising those at risk is called for.

25. Nurse Guo told the court that she was familiar with the screening process. She said that it usually took about half an hour[14] and during that time she administered the RSA, conducted the necessary routine tests (pregnancy, blood pressure, urine) and made physical observations.[15] She acknowledged that there were always time constraints but that she did not feel pressure or that she needed to finish all the RSAs if they could not be properly completed during a shift.

26. Nurse Guo told the court that she remembered the specific interaction and that she was "*able to gain rapport very quickly with Ms Knight, she was receptive to questioning, open in her engagement with me and maintained good eye contact throughout the assessment*."[16] Further, Nurse Guo stated that it was her usual practice, as well as completing the structured RSA to ask open questions. She stated: "*I prompted Ms Knight and asked whether she wanted to talk to anyone about any particular health issues and she did not raise any concerns or issues with me."*[17]

27. There is a place on the form to record answers to this type of open question, but Nurse Guo told the court that nothing raised her concern or needed recording. Based on the information obtained during the screening process, the algorithms did not recommend referral to a mental health nurse and Nurse Guo did not consider referral based on other clinical grounds or observations.

28. The court is aware that the structure of the mental health section of the RSA and the algorithms it deploys are based on extensive research under the supervision of Professor

[12] Vol 1,Tab 17 – see also Tab 45.
[13] Vol 5 Tab 85E at p145.
[14] I note that Ms Sheehan stated "just going through the RSA itself can take an hour" 6.4.22 T.11.23.
[15] 4.4.22 T36 43- 44.
[16] Vol 11 Tab 29 at [6].
[17] 4.4.22 T45 6-10.

Kimberlie Dean.[18] It was introduced as a custom-built tool to replace the previous Kessler 10 assessment, which although widely used in the community was not validated for a correctional setting. Dr Spencer, Clinical Director, Custodial Mental Health told the court that the tool provided a structured approach to patient risk assessment. She said the RSA "*was developed from looking at patients who had a specific – different diagnoses, but specific diagnoses, and trying to tease back what questions should be asked and in what way they should be asked in order to get a higher number of people being referred for treatment than what was previously happening. So there is a bit of method to the madness, even though I can appreciate it does look like they're very closed questions being asked*."[19]

29. The court accepts that this inquest is not the correct place to fully evaluate the new screening tool. It is nonetheless clear that whatever open questions Nurse Guo asked Kerry, she did not balance the answers against information that was also available to her on the Justice Health Electronic Health System (**JHeHS**). While Nurse Guo told the court that it was her usual practice to have regard to alerts and active health conditions, she did not on this occasion. Nurse Guo told the court that Kerry denied a history of mental health conditions which included PTSD. She told the court that would have specifically asked Kerry about PTSD, using the script available to her.

30. Kerry's apparent denial of PTSD to Nurse Guo (having not long before informed the CSNSW SAPO, Joshua Evans that she had untreated PTSD, anxiety and depression) is certainly curious. The denial was also clearly inconsistent with an "active alerts and health conditions" which were recorded on the electronic medical record available to the nurse. As Ms Sheehan, Deputy Director of Nursing and Midwifery for Custodial Health at JHFMHN pointed out, this inconsistency should have been identified and interrogated further. While Dr Spencer made it clear that a history of PTSD and depression was not of itself enough to *automatically* prioritise a referral to mental health, the inconsistency should certainly have been explored and may have prompted further useful information about Kerry's current mental state.

31. It is impossible to know why Kerry did not disclose her ongoing PTSD to Nurse Guo. I think it probable that Nurse Guo has misjudged the level of rapport which actually existed between them. On the other hand it may be that Kerry was simply tired and unwilling to elaborate on her mental health status at that time, knowing that she had already disclosed it once that afternoon to correctional staff. What is clear is that Nurse Guo *would* have referred Kerry for mental health review had she known the detail of her earlier presentations,

[18] Vol 1 Tab 33A at [7-8].
[19] 7.4.22 T34.3-14.

including the assessment on 28 April 2020.[20] This information was readily available to her. Not checking JHeHS was a missed opportunity and one that as we shall see had a cascading effect on the care offered to Kerry. Counsel for Kerry's family characterised Nurse Guo's screening as inadequate, incompetent and careless. In my view a distinct lack of curiosity certainly infected the process.

32. A further issue was raised by counsel assisting in relation to the screening tool. Even leaving aside the failure to check alerts, there was a clear discrepancy on the face of the answers Kerry gave which, if noticed, could also have prompted further exploration. The record suggests that although Kerry denied thoughts of suicide, self-harm or harming others, she also answered "No" when asked if she "would be able to cope in prison".

33. In oral evidence Nurse Guo explained that this was a simple error, in that she had clicked the wrong button and should have clicked "Yes." Nurse Guo said that if Kerry told her that she would not cope, the issue would have been explored. In any event Nurse Guo expressed the view that it was clearly a mistake in that it was incongruent with other answers. She agreed that it was likely to have been an error made when moving quickly through the questionnaire.

34. I accept that it is most likely that Nurse Guo made an error in recording "No" when she meant to record "Yes". I note that the question occurs in a section when Kerry's preceding answers had all apparently been "No". Further this explanation is largely consistent with what Kerry had told the SAPO earlier that day.

35. Dr Spencer told the court that a team within JHFMHN was currently reviewing the RSA in relation to this issue. She stated that "*it was agreed that the wording of the question in relation to whether an inmate thinks they will cope in prison will be changed from "Do you think you will be able to cope in prison?" to "Do you think you will be unable to cope in prison?" The purpose of this change is to reduce the potential for error and align this question with other questions in that section of the RSA.*"[21]

36. While I understand the proposed change may make the script flow more easily in that section of the tool, I remain cautious about an approach which results in the possibility of the questioner and patient getting caught in a run of answers which appear to suggest a logical pattern. Any change should *encourage* not discourage the critical utilisation of a tool of this sort.

[20] This record (Vol 5 Tab E at p11) shows that just 10 months prior to Nurse Guo's assessment Kerry disclosed a history of depression, anxiety, PTSD. Details of her trauma are recorded and there is reference to psychiatric medication she had been prescribed.
[21] Vol 1 Tab 33A at [9].

37. Some of the issues identified with the use of RSA were the subject of recommendations suggested by counsel assisting and by the family's legal representative and I will return to those issues shortly.

Initial placement

38. Kerry and her cohort were placed in F Wing. The COVID-19 restrictions meant that they were greatly confined in the time they were permitted to be out of their cells. Officer Natalie Dickson told the court that the experience of imprisonment during periods of quarantine can be particularly frustrating for inmates. "*Obviously, they're cooped up for a lot more hours*."[22] She explained inmates found it frustrating to have to wait for long periods of time before they could follow up issues like referrals and account balances. I have no doubt those conditions increased the baseline levels of frustration in the block.

39. On 1 March 2021, the Aboriginal Services and Programs Officer (SAPO) Ben Patterson attended the Induction Wing to deliver an orientation procedure. He introduced himself to Kerry and offered further information. He reported that she stated that she did not need anything, and would ask the officers if she did. She made eye contact and he stated that he did not observe any signs of shame or distress.[23]

40. The court heard evidence from inmates who were in Kerry's cohort about the pressures of custody whilst in quarantine. One inmate told the court that she and Kerry talked to pass the time, but that inmates were not given books, pens, pencils or paper or access to any courses. The Court heard that these things would have made a big difference in keeping inmates occupied during quarantine.[24]

41. Further, the court heard evidence that Kerry experienced frustration in relation to making telephone calls. CSNSW records indicate that between 1 and 5 March 2021, Kerry attempted to make 44 calls, 42 to her daughter and other family members. None of these calls connected.[25] While the exact reason for this problem is unclear, other inmates on F Wing were certainly aware that Kerry was unable to contact her friends and family, and that Kerry was upset because she couldn't make calls.[26]

Kerry's self-referral forms

42. JHFMHN has developed a system for inmates to self-refer to medical services without having to disclose private medical issues to custodial staff. The Justice Health Patient Self-

[22] 5.4.22 T30.15-16
[23] Vol 1 Tab 18 at p1.
[24] 7.4.22 T80 21-43.
[25] Vol 1, Tab 44 at [74].
[26] Vol 1 Tab 35 at p7.

Referral Form (**PSRF**) should be available throughout all custodial areas. The PSRF is designed to provide patients with a direct means of alerting JHFMHN staff to non-urgent medical matters or to request an appointment with specific health staff members. The forms are filled in by the patient or their representative and placed in locked boxes which are usually located in the common areas adjacent to their cells. To ensure confidentiality only JHFMHN staff have access to the boxes. The forms may also be delivered directly to a health centre clinic by the patient or handed directly to a nurse during medication rounds. The forms, once received, are triaged and actioned by a Justice Health Nurse. If the system works these forms should provide a great safeguard for inmates seeking help.

43. On 3 March 2021 Kerry obtained a form and wrote (in capital letters),

"I NEED TO DISCUSS MEDICATION FOR ANXIETY, DEPRESSION AND PTSD ASAP. I CAN'T SLEEP. I CAN'T EAT. I'M SLIPPING BACK."[27]

44. To someone outside the system the note is suggestive of great pain and imminent risk and would seem to require urgent follow up. It names serious mental health conditions, describes significant symptoms and suggests a worsening mental health state. To a layperson outside the correctional setting, one would imagine that triaging such a request would involve consulting past records if they were available to ascertain what "slipping back" to an earlier condition might entail. To an outsider it might also trigger consideration about whether Kerry should be left alone, without a cellmate. It should also be noted that Kerry is likely to have anticipated action given that in the past similar self-referral forms she had lodged had resulted in an almost immediate response.[28]

45. The court heard from the nurse who reviewed the self-referral form, Mr Gregory Turner. Nurse Turner completed his general nurse training in 1984 and had been employed by JHFMHN at Silverwater Women's Correctional Centre on a permanent part-time basis since 2012.

46. Nurse Turner did not meet or treat Kerry. He told the court he had various responsibilities that shift including being ready to respond to any emergency call-ups, completing documentation in relation to inmate transfers and reviewing self-referral forms as required. He said it was common to have about 20 to 30 self-referrals to review, assess and prioritize during any night shift[29].

47. Understandably given the volume, by the time he came to give a statement in January 2022 he had no specific memory of triaging Kerry's form. Relying on his general practice he told the court that when he receives a form, he checks the Patient Administration System (**PAS**)

[27] Vol 1 Tab 80 at 7.
[28] See for example a self-referral form lodged on 17 April 2020 and one lodged on 11 June 2020 (Vol 3 Tab 80 at p 13 & 12).
[29] Vol 1 Tab 33C at [6] and 5.4.22 at T5.1.

to confirm if there is a current referral and he may upgrade the priority if this appears called for. Where there is no waitlist entry, he creates one. On occasion he will review the RSA.

48. Nurse Turner gave evidence that there is a "Waiting List Priority Level Protocol." There are five levels in descending order of urgency with each level being allocated a response time. Urgent referrals, the highest level of priority (level 5) should be actioned within 1-3 days, semi urgent (level 2) 3-14 days and non-urgent (level 3) 14 days – 3 months.

49. Nurse Turner prioritised Kerry's self-referral as non-urgent (level 3). It appears that he relied heavily on the RSA. He explained his reasoning to the court, "*I actually accessed the reception screening assessment that had been done a number of days before, when she came in. I didn't see anything regarding anxiety or PTSD. I saw that the question was asked, had she had any history of depression. She'd stated "Yes". That's in that past month; the question usually is: have you got a history of depression, anxiety, PTSD in the last month?" She stated she had but she wasn't on medication and she had not had any symptoms of depression in the previous month: so she had past history depression. So, just based on that, I – that didn't set off any alarm bells for me, so with that – I also noticed that there was no mental health waitlist created,…I felt that it was non urgent, just in view of the fact that it was history of depression, where there hadn't been any signs and symptoms in the previous month."*[30]

50. Nurse Turner elaborated further on his reasoning process, stating that if Kerry had already been on a wait-list in a non-urgent category he might have escalated her case to semi-urgent. He also stated that if he had he seen the entry on her electronic records some ten months earlier relating to her PTSD, history of sexual assault and depression he *"would have escalated it to semi-urgent, for starts and I would have made sure that I'd taken that form to the mental health people, on the morning, before I left my shift and just said "This girl has been on medication when she came in last time. She's been here a number of days. Can you people see her and just see if you can get her medicated?*"[31]

51. In contrast to the approach he took, Ms Therese Sheehan, Deputy Director of Nursing and Midwifery, Custodial Health informed the court that in processing the form, Nurse Turner was obliged to review JHeHS (including alerts and active health conditions), PAS and the e-progress notes (which include the RSA).[32] Ms Sheehan told the court that reference to depression, opioid dependence and PTSD in Kerry's active health conditions when read with the self-referral form ought to have resulted in a *minimum* of "semi-urgent review". It is noteworthy that Dr Spencer also saw a "semi-urgent review" as appropriate.

[30] 5.4.22 T 19.
[31] 5.4.22 T8.11.
[32] 6.4.22 T15.2-6.

52. Nurse Turner confirmed that although he sometimes had regard to alerts and active health conditions, in this case he did not.[33] This is the second occasion where JHFMHN staff, in breach of policy, did not access Kerry's available records including her alerts and active conditions. With hindsight it appears that taking this further step may have changed the health support Kerry was offered. It is a another missed opportunity. If Nurse Guo had looked at JHeHS, it may have impacted the information caught by the initial screening, something Nurse Turner then considered. Even if that had not occurred, he should still have gone to the electronic record himself to properly assess the self-referral form he was processing. As counsel for Kerry's family pointed out, Kerry's appeal was heartfelt and extremely concerning and when read in the correct context should have been given some priority.

53. At the conclusion of evidence on this issue I have no doubt that the self-referral form should have been categorised as *at least* semi-urgent and that best practice would have been to send a nurse to the cell as soon as possible for a brief preliminary discussion. Had this occurred it may even have been open to JHFMHN to consider whether there should be any change to the advice it could offer CSNSW about cell placement. As it happened the opportunity was missed.

54. The court was asked to consider a number of recommendations in this area and I will return to them shortly.

The actions of the Justice Health nurses involved in COVID 19 screening

55. The court obtained extensive evidence about the interaction between JHFMHN nursing staff and Kerry on the morning of her death. There were accounts from involved nurses, correctional staff and other inmates. The court was also able to review CCTV footage of the area and listen to recorded "knock-up" calls that Kerry made around that time. Various written records of what had occurred were also produced. I have carefully considered all the available evidence about the contentious issues that arose both in relation to the nurses' record keeping and in relation to their professional conduct at the cell door.

56. During the period of Kerry's incarceration, JHFMHN was administering a COVID-19 checking regime on all new inmates. On the morning of 5 March 2021 Nurse Nyarai Mudzingwa and Nurse Monica Nguyen attended F block where Kerry was housed to conduct COVID-19 quarantine and welfare checks and to deliver medication. Nurse Mudzingwa was an experienced nurse who had been conducting these kinds of check for more than 12 months by this time. She had broad experience in nursing and had worked

[33] 5.4.22 T9.36.

as a clinical nurse specialist. Nurse Nguyen was less experienced but had been working for the JHFMHN since 2016.

57. During oral evidence the court came to better understand how the process worked in practice. Nurse Mudzingwa told the court that in general terms they worked as a team and that one nurse gave medication, checked each inmate's temperature and inquired if there were other potential COVID symptoms, or welfare concerns. The other nurse recorded the information in short form on a paper list of inmates they carried with them from door to door. Once back at the clinic they would fill out the daily check list for each prisoner, transferring information that had been jotted down earlier. Nurse Mudzingwa told the court that on the day in question, once back at the clinic, she had written down Kerry's name, date of birth, MIN number and temperature, and then given the form to Nurse Nguyen to complete.[34] It was thus clear that the hard copy checklist that was before the court was completed back at the Clinic and the information from it later entered in the electronic notes. Counsel for JHFMHN submitted that there was no issue with the procedure as it was conducted. It was submitted that a year into the pandemic nurses would have no difficulty remembering the standard questions they had to ask, nor any difficulty remembering to ask whether anything else could be done to help or support the inmate.

58. The relevant COVID-19 Quarantine Patients Daily Checklist dated 5 March 2021 completed in part by both Nurse Mudzingwa and Nurse Nguyen records an absence of any COVID-19 symptoms, a temperature of 36.3 , that Kerry was feeling "fine", had no thoughts of self-harm, could guarantee her own safety and the safety of others and that there was nothing further the nurses could do to "*help and support"* her.[35] The corresponding entry in the clinical notes reads "*seen for routine quarantine check. COVID-19 checklist attended. Afrebrile. Nil c/o COVID 19 symptoms voiced by pt. Nil other issues voiced*." [36]

59. I have considered submissions made by counsel for JHFMHN in the context of all the evidence. I do not accept that the nurses asked each question on the written form. They took temperatures and may have asked about basic symptoms, however it is inconceivable, particularly given the knock up call, which occurs shortly after they leave the vicinity, that the nurses asked Kerry whether there was anything else they could do to "*help and support*" her and received a negative reply. I do not accept that this occurred.

60. The court learnt that although most of the electronic record was written before Kerry's death, Nurse Mudzingwa returned later in the afternoon and added "*Nil other issues voiced"* without making it clear that this part of the record was added in retrospect. It was unfortunate that the nurse initially told the court that she did not recall having added to the original

[34] 19.5.22 T12.32 – 13.11.
[35] Vol 5 Tab 85 C at 12.
[36] Vol 1 Tab 28A at Annexure A.

record[37]. I found her evidence on this issue implausible at the time and was not surprised when she returned to court and was able to give further evidence outlining a clear recollection of her conduct.

61. Nurse Mudzingwa told the court that after attending to Kerry's unsuccessful resuscitation attempt that afternoon she "*heard one of the officers saying "This patient has been knocking up", so I went back when we finished the resuscitation to see if I had missed anything and then to also check with my checklist, my COVID checklist, to see that the other nurse hasn't written anything that I missed, that's why I went back to my notes*".[38] She told the court that she did not remember discussing this extra notation with anyone but she thought it important to "*see if I had missed anything and just add on. But unfortunately, I didn't add on the time that I had added this information*."[39]

62. Nurse Mudzingwa acknowledged that the timing of a retrospective note should be made clear when it was added. This is particularly so when the circumstances are such that there is a real dispute about exactly what Kerry disclosed to the nurses on their visit and where a truly contemporaneous note, not one written after serious issues had been raised, would have been of some considerable value.

63. Officer Dickson told the court that on the day in question she had been involved in the escort of nurses on duty doing COVID-19 testing and delivering medication. In her statement dated 9 December 2021, and without having viewed the relevant CCTV, she recalled that at some point between 10 am and 10.30 she was in the vicinity of cell 5 where Kerry was housed. She stated *"I recall Ms Knight speaking to the nurse about being of ill health, I remember she spoke about her blood pressure and having sore arms. The nurse advised Ms Knight that they were only doing pills and temperatures at that time and that she should contact the officers."*[40] Later she told the court that she reported this exchange to Senior Correctional Officer Kumar.

64. Officer Dickson told the court that she also heard Kerry complain of ill health later that morning when she was distributing lunches. At that time she heard SCO Kumar advise Kerry that JHFMHN had been notified.

65. In oral evidence Officer Dickson maintained that she had a clear memory of the interaction between Kerry and the nursing staff and she was not shaken by cross-examination. She gave the appearance of being an honest witness, somewhat distressed by the events she had witnessed, who was doing all that she could to assist the court. Her recollection contained some detail. She said she remembered looking at Kerry when she was speaking

[37] 6.4.22 T9.20 onwards.
[38] 19.5.22 T 23.20.
[39] 19.05.22 T 23.23.
[40] Ex 1, Tab 14 at [4.1].

to the nurse and that she recalled Kerry touching her arms when she said she had pain there.[41] She remembered Kerry's frustration and she recalled a nurse of "African appearance" saying that they were only doing pills and temperatures and that she should contact the officers.

66. Officer Dickson's evidence sat in stark contrast to the evidence of both JHFMHN nurses, Nurse Mudzingwa and Nurse Nguyen. Both denied that any complaint or discussion of symptoms took place that morning at the front of Kerry's cell. Nurse Mudzingwa gave evidence that if *"chest pains or arm pain"* had been mentioned she would attend straight away, "*then I have to do an assessment and ask the officers to escort this patient to the clinic so we can do a proper assessment*."[42] Nurse Nguyen indicated that had Kerry mentioned "*pain in the arm and a high blood pressure*" this would have constituted a medical emergency requiring escalation to the clinic. She regarded it as "*highly improbable*" that Kerry mentioned "*blood pressure and having sore arms*" and rejected "w*holeheartedly*" that either nurse dismissed such serious symptoms with the words "*we're only doing pills and temperatures. You should contact the officers.*"[43]

67. The seriousness of the alleged complaint was also confirmed by Ms Sheehan who informed the Court that if nursing staff at the clinic had been informed they would definitely go immediately to the cell to rule out a cardiac issue.[44]

68. Submissions for both JHFMHN and the involved nurses asked the court to review Officer Dickson's evidence in the context of the available CCTV footage. It was submitted that the CCTV footage shows that Officer Dickson did not move to the door of cell 5 for any length of time until after the nurses had moved away. Further it was submitted that although she was in the vicinity of the cell for around 28 seconds, she appears distracted by her facemask and another inmate for at least part of that time. It is slightly later, that she goes back to cell 5 and appears to have a discussion at the door but by that time the nurses are leaving the block.

69. Counsel for JHFMHN and the nurses submitted that review of the CCTV footage shows Officer Malhotra engaged in a conversation with the inmates at the door of cell 5 in the presence of Officer Dickson. Officer Malhotra is seen to shut the door. At this time the nurses are no longer present. Further it was submitted that it was highly implausible that two experienced nurses would disregard a complaint of "*arm pain and high blood pressure*" which clearly disclosed the possibility of a serious health risk.

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[41] 5.4.22 T34.10.
[42] 6.4.22 T49.24.
[43] 19.5.22 T50.37 onwards.
[44] 6.4.22 T27. 2-3.

70. Having reviewed all the evidence, I have no doubt that Kerry complained of ill health of some sort and that she requested assistance. I note that Kerry's cell mate gave evidence that Kerry had complained of pain and pins and needles in her arm on numerous occasions when nurses had come to the door.[45]

71. The fact that a complaint was made is also consistent with Kerry's knock up call just after the nurses left the block. She tells SCO Kumar "*Hi, I really need to see a nurse. I buzzed up twice yesterday and nothing happened, I got really high blood pressure, its through the roof. I'm really dizzy. I'm getting sharp pains down my left arm and I really need to see someone…Kerry Knight*."[46] SCO Kumar tells her that nurses will be there soon to check her temperature. Kerry tells SCO Kumar that temperatures have been taken and that she "*tried to talk to them and they shut the door in my face*."

72. In my view the knock up call makes it very clear that Kerry was trying to get medical attention around that time and was thwarted in her attempt. Given that it must have been officers, not nursing staff who would have controlled the door, it is difficult to accept that the *nurses* literally closed the door in her face. I accept on a review of the CCTV evidence that it is possible that Kerry's specific complaint about blood pressure and arm pain may have actually occurred during her conversation with Officer Malhotra and Officer Dickson *after* the nurses had already moved away. Nevertheless I think it likely a more general request for assistance had already been rebuffed by the nurses who were concentrating on taking temperatures and dispensing medication.

73. In all the circumstances I am unable to make a firm finding as to exactly what Kerry said to the nurses and what she said to the officers at her door directly *after* the nurses left. Nevertheless I reject the nurses' evidence that *no* complaint at all was made in their hearing. Kerry's recorded knock up call, the evidence of her cell mate and Officer Dickson's recollection of Kerry's dissatisfaction make it highly implausible that she did not communicate something to the nurses during the short time they were at her door and taking her temperature.

The knock up calls

74. About half an hour after Kerry's knock up call to Officer Kumar, she knocked up again and this time spoke with Officer Pittas. The call is logged at commencing at 10:05.46 am and the tone of Kerry's voice indicates growing tension and fear. She says "*Hi, um I really need to see a nurse. Um um, I'm really dizzy, I got really high blood pressure, um which I'm not medicated for at the moment. I'm getting really dizzy and like, I'm starting to get pains*

[45] 7.4.22 T81.23-28.
[46] Vol 1 Tab 47 (audio) and also Exhibit 2 (transcript), p1.

down my arm and my chest and I feel like I'm going to faint."[47] The officer tells Kerry that she will arrange for an officer to go down to the cell.

75. At 10.13am the CCTV footage depicts Officer Kumar walk towards cell 5 and it appears that door opens. At the time of giving evidence Officer Kumar was unable to say what conversations took place with Kerry or her cell mate. In retrospect his apparent failure to call for a medical review at this time is another missed opportunity.

76. There were thus two knock up calls, the first occurring around 9.30 am to Officer Kumar where Kerry reported that her medical concerns had been ignored by the nurses. Officer Kumar gave no satisfactory explanation as to why he did not ask the nurses to immediately attend Kerry. Further when he was taken to the CSNSW Policy which required him to go to the cell after such a call he had no satisfactory response.[48] His attendance at her cell later that morning only occurs after the second knock up call and a direction over the radio to attend cell 5 to check on Kerry. [49] Noting the verbal system between the two agencies for requesting medical assistance to inmates, there is no documentary evidence to corroborate whether a direct request was ever made for a nurse to see Kerry. In any event, review of the CCTV footage does not reveal any attendance by JHFMHN staff upon Kerry following the 10:05:46am knock up call.

77. CSNSW drew the court's attention to the provision of Chapter 5.5 "Cell security and alarm calls" of the Custodial Operations Policies and Procedures. This policy specifies the circumstances in which a correctional officer must immediately go to an inmate's cell – including report of a "…*medical emergency or serious health problem*…"

78. CSNSW submitted that SCO Kumar acted in accordance with the policy in respect of both knock up calls received on the morning of 5 March 2021. In respect of the first knock up call, CSNSW submitted that SCO Kumar's evidence that Justice Health nurses had reviewed Ms Knight immediately prior to the 9:33am knock up call, and that they not taken any further action properly reassured him that the situation did not qualify as a medical emergency.[50]

79. In respect of the second knock up call after 10 am, (where Kerry reported chest pains), SCO Kumar was instructed to attend Kerry's cell to check on her, and did so, in accordance with the policy.[51]

80. The court became aware that the process of communicating medical concerns between CSNSW and JHFMHN is usually by telephone. Counsel for Kerry's family suggested a

[47] Exhibit 2, p1-2.
[48] 5.4.22 T58.9-18.
[49] 5.4.22 T60.25-34.
[50] NSWCS Submissions at p2-3.
[51] NSWCS Submissions at p3.

recommendation to better document these verbal requests for assistance and I will return to that issue shortly.

What did Kerry's friends know about her health at that time?

81. The court received evidence from a number of women who were housed in F Wing with Kerry about her presentation in the days prior to her death. Kerry had raised her mental health with inmates on a number of occasions. One woman reported that Kerry had said words to the effect "*If I didn't meet you girls, I would have probably killed myself*".[52] Kerry's cellmate told the court that Kerry had been voicing thoughts of suicide since entering custody, saying that she "*didn't want to be here anymore*"[53]. Further, Kerry had demonstrated to her cellmate the method in which she ultimately took her life, with reference to a ligature point in their cell.[54]

82. The court received expert evidence from Dr Danny Sullivan. One of the issues to which he spoke was the effectiveness of peer education and peer support in prisons. The court was referred to research in this field, notably an article entitled "A systemic review of the effectiveness and cost effectiveness of peer education and peer support in prisons."[55]

83. Dr Sullivan observed that Kerry's cellmate was privy to reports of suicidal ideation, however, did not report these to staff. He noted this was not uncommon in the prison environment, where inmates may not wish to report their peers to staff lest they be seen as untrustworthy.[56] In Dr Sullivan's view, a peer support program (such as the Listeners scheme, discussed further below) may offer an opportunity for inmates contemplating suicide to receive assistance, or for inmates to disclose concerns about the mental health of others, without direct contact with custodial staff. [57]

84. Dr Sarah-Jane Spencer told the court that while she was not aware of any such programs in NSW, although she had experience of the "Listeners Program" model operating in the United Kingdom. The Listeners scheme is a specific peer support intervention focused on prevention of suicide and self-harm[58] in prison. Dr Spencer explained that this evidence-based program is well established. Inmates can have access to other trained inmates or "listeners". The role of the listener is a valued role in custody. Dr Spencer outlined that listeners have access to the phone system at different times and can be available to patients in safe cells when staff are not available. Phones are available on wings for

[52] Vol 1 Tab 36 at p6.
[53] Vol 1 Tab 38 at p3.
[54] Vol 1 Tab 38 at p5.
[55] Vol 6 Tab 92 at Annexure A.
[56] See for example Vol 1 Tab 35 at p5.
[57] Vol 6 Tab 91 at p10.
[58] Vol 6 Tab 92 at Annexure A, p17.

inmates to access listeners.[59]

85. In my view trialling such a program would be of great value and should be immediately prioritised.

Kerry's death is discovered

86. A review of the CCTV discloses that Kerry was alone in her cell from about 10.33 am until 12.49 pm. It is likely that she continued ruminating about her problems. She may have felt hopeless about whether she would ever receive the help she had requested. It is impossible to know if the symptoms she reported were primarily physical or psychologically based. Dr Spencer agreed that they were at least consistent with a panic attack[60]. While we cannot be sure what finally triggered Kerry to take action, it is likely her decision was impulsive. Unfortunately once her cell mate was taken away for a court appearance, Kerry was left to face her despair alone in an enclosed space with obvious hanging points.

87. At 12.48 pm Correctional Officer Markanday commenced attending the cells to read out inmate's account balances. When he opened cell 5 he saw Kerry hanging from her neck by a piece of purple coloured torn bed sheet attached to the shower curtain rail.

88. First Aid was swiftly rendered by a number of custodial officers on F Wing, including Correctional Officer Markanday. No less than seven JHFMHN nurses quickly attended and assumed responsibility for CPR.[61] At 1:10pm paramedics from NSW Ambulance arrived to render assistance.[62] Despite these interventions, Kerry was unable to be revived and was pronounced dead at approximately 1:30pm.[63]

89. In my view no issue arises in relation to the resuscitation process and I note that a defibrillator was almost immediately available.

Hanging points

90. The cell Kerry was housed in was an older style cell. I conducted a view to Silverwater Women's Correctional Centre on 31 May 2021 and observed the cell where she died.

91. The court had the evidence of Wayne Taylor, General Manager, Statewide Operations, NSW Department of Communities and Justice.[64] In March 2021, at the time Mr Taylor prepared his statement, F Bock cells, where Kerry had been housed, were still in use for COVID-19 isolation purposes. He indicated that the cells would continue being used for

[59] 7.4.22 T17.42 – 18.15.
[60] 7.4.22 T20.29-30.
[61] See for example Vol 1 Tab 28A, [12]-[13]; Vol 1 Tab 29A, [6]-[7]; Vol 1, Tab 30 at [6] – [14].
[62] Vol 1 Tab 30 at [14].
[63] Vol 1 Tab 33D at [14].
[64] Vol 2 Tab 79A.

this function. He stated that the cells were standard cells and thus *"not deemed anti ligature in design or cell furnishings or fit out*."[65]

92. Mr Taylor noted that although CSNSW has a program focussed on refurbishing older style cells, the prioritisation process did not identify the cells where Kerry was housed as being of the highest priority. He explained that CSNSW's focus is on having sound risk management protocols and removing inmates from normal cells if they are at risk. Decisions about cell placement are based on principles of "*least restrictive care*", but if an inmate at Silverwater Women's Correctional Centre is identified as being at risk they can be placed in a "camera cell" or an "assessment cell" in the Mental Health Screening or Induction Units. He stated that had Kerry been assessed as having been at significant risk this is what would have occurred.

93. The real difficulty in managing risk in this way is that it is actually very difficult in a population where many have risk factors to accurately predict who will make a suicide attempt. It is well-known that some inmates downplay their risk factors because they know that camera or assessment cells can be so uncomfortable. For this reason CSNSW also manage risk by controlling cell placement, in particular by placing inmates where necessary "two out". On making these decisions they are dependent on receiving sound medical advice.

94. In this case medical staff missed opportunities to get a full understanding of Kerry's deteriorating mental health and thus communicate her changing risk profile to CSNSW

Cause and manner of death

95. A limited autopsy was conducted by Dr Marna du Plessis on 9 March 2021. A post mortem computed tomography (CT) scan showed resuscitation injuries consistent with the medical intervention she had received. There were no suspicious findings or findings that indicated evidence of injury or significant natural disease. There was a non-circumferential ligature abrasion on her neck which was consistent with hanging. I note that toxicological analysis was performed. The only drug detected was a non-toxic concentration of Delta-9-tetrahydocannabinol (THC), this played no part in Kerry's death.

96. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention.[66] I note that Kerry did not leave a note or final communication. Nevertheless it is abundantly clear that she had indicated her mental distress to numerous people in the lead up to her death. The steps she took to

[65] Vol 2 Tab 79A at [5].
[66] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336)

make a ligature indicate her death was not accidental. There is nothing to suggest that Kerry was thought disordered or unable to form intention. In my view the evidence establishes that she made a decision to end her life at some time on the morning of 5 March 2021. Given the circumstances that final decision appears to have been somewhat impulsive and occurred at a time of great despair. I accept Dr Sullivan's evidence that a series of frustrations around this time would have reinforced her sense of powerlessness.[67] I accept that the decision to take one's life is usually multifactorial.

The need for recommendations

97. Counsel assisting put forward a number of recommendations arising out of the evidence for the court's consideration. Further recommendations were provided by legal representatives for Kerry's family. Some of the recommendations overlapped and I will deal with them together.

98. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

Peer Support

99. Counsel assisting suggested a joint recommendation to JHFMHN and CSNSW to pilot and support a peer support program based on the existing evidence-based research and informed by the UK model, the Listeners Program. It became apparent that Kerry's fellow inmates were aware of some of her struggles because she could open up to them. However, there appeared to be a reluctance to disclose these concerns to CSNSW and/or JHFMHN staff. A program that skills fellow inmates to support others struggling with mental health and other challenges in custody may promote a culture where inmates can come forward and seek assistance, without direct contact with custodial staff. Such a program may reduce incidents of suicide and self-harm in custody.

100. Counsel for JHFMHN submitted that while JHFMHN supported the introduction of such a pilot it would need to run by CSNSW. Nevertheless in my view it is a program that would need the support and expertise of JHFMHN. Dr Spencer told the court that there had been discussions over the years between CSNSW and JHFMHN about such an initiative and that she would support her agency being involved.

101. This recommendation was supported by both CSNSW, JHFMHN and Kerry's family. In my

[67] 7.4.22 T66.11.

view a pilot program has the capacity to save lives and should commence as soon as possible.

Hanging Points

102. Counsel assisting, with reference to the key recommendation of the *Royal Commission into Aboriginal Deaths in Custody*, suggested a recommendation that hanging points be removed from cell 5 and others in F Wing, or that these cells be decommissioned as soon as possible.

103. The Commissioner of CSNSW was of the view that there would be limited utility in refitting or decommissioning the cells in F Wing at Silverwater Women's Correctional Centre to address the presence of ligature points. In this respect, the court's attention was drawn to:

a) The design of the cells includes access to open-air balconies. Refitting the cells to be anti-ligature would not be possible whilst retaining unregulated access to the open air balconies.

b) These 'normal discipline' cells are used to house female inmates who have been assessed at no risk of suicide or self-harm. If an inmate was assessed as presenting a risk, they would be removed to appropriate accommodation; and

c) Cells housing inmates at higher risk of suicide or self-harm are being prioritised by CSNSW for refitting for the removal of hangings points as part of the refitting works to commence in November/December 2022.[68]

104. In written submissions, Kerry's family emphasised support for more cost-effective ways to reduce the risk of suicide by hanging, including the introduction of peer support programs or enhancing the availability of protective factors.[69] Kerry's family also pointed to the self-referral process as a means by which inmates could alert JHFMHN staff to concerns about the welfare of an inmate.[70]

105. Having considered all the submissions on this issue, I am of the view that given the real difficulty of predicting suicide there remains a need to decommission these kinds of old cells as soon as is practicable.

Flagging past entries

106. Counsel assisting made a number of recommendations to JHFMHN. One suggested that the Network give consideration to providing capacity in the electronic record to "red flag"

[68] NSWCS Submissions at [30] – [34].
[69] Submissions of the family at p27.
[70] Submissions of the family at p28.

the most critical past entries so that they are accessible for nurses at reception. This arose out of evidence given by a number of witnesses who when taken to a particular past entry on Kerry's record felt that it may have prompted them to take different action, had they seen it at the relevant time. I have considered the issue carefully and on reflection I am persuaded that the current system was sufficient, if it had been used properly.

107. JHFMHN did not support a recommendation aimed at introducing additional "red flagging". The court was warned against suggesting something which might reduce the currency of the existing "alerts and active health conditions" and therefore have the potential to adversely impact patient safety. JHFMHN submitted that both Nurse Guo and Nurse Turner *should* have given consideration to the active alerts and did not. Had they done so and turned to the electronic record that was available to them Kerry's situation may have been given a higher priority.

108. Having considered all the material before me I accept counsel for JHFMHN's warning in this regard and I decline to make the recommendation.

109. Counsel for the family suggested a number of further recommendations aimed at improving the medical reception process. Firstly it was submitted that the court should make a recommendation that all inmates should be reviewed by both a primary health and a mental health nurse. This recommendation arose out of the expert evidence Dr Sullivan gave about how the process works in Victoria. While the suggestion may have merit, I am of the view that on the very limited evidence available to me and taking into account the complex matters I would need to consider that it would be beyond scope to make such a recommendation in this inquest.

110. Counsel for the family also suggested that the Justice Health Policy 1.225 "Health Assessments in Male and Female Adult Correctional Centres and Police Cells" be amended to include at 3.2.1 a requirement for the nurse conducting the RSA to undertake a review of the medical records. The suggested wording was,

Where possible, the RN or EN should undertake a review of any recent medical records held by Justice Health in relation to the patient, particularly in circumstances where the patient is not responding or communicative or where information received during the assessment is inconsistent with any active or inactive PAS alerts or health conditions.

111. This recommendation was not supported by JHFMHN. It was pointed out that the meaning of "recent" is unspecified and could thus cause some uncertainty. It was also noted that JHeHS and PAS records are available to reception staff and should provide an effective summary of the known active conditions based on previous periods of incarcerations. If the previous period of incarceration does not give rise to an *active health condition* it was

submitted that it would be an inefficient use of resources to *require* reception staff to interrogate the records.

112. However it appears to me the suggested amendment may be helpful and provide added guidance. The policy change suggested takes into account the resource issue, making it clear that this review should occur *where possible* and particularly where there are evident inconsistences or where the patient is not responsive. I intend to make the recommendation.

113. Counsel for the family also suggested that consideration should be given to mandating that an RSA should be documented on the JHeHS progress notes. I note that JHFMHN did not see the utility of this, noting that the RSA is available to all practitioners who have later contact with a patient.[71] For this reason, I have decided not to make the recommendation.

Training for those using the RSA tool

114. Counsel assisting suggested a recommendation aimed at ensuring reception nurses receive training about the importance of asking open questions and displaying curiosity when using the tool.

115. Counsel for JHFMHN submitted that it was Nurse Guo's evidence that she *did* ask open questions. Further it was submitted that training on these basic issues was unnecessary and the recommendation was not supported.

116. However, the court was troubled by the fact that both the nurse who conducted the RSA and the nurse who triaged the self-referral form should have reviewed previous JHeHS records and did not. Counsel for JHFMHN submits that this is not a systemic issue but an example of human error. Human error can be overcome by good training. Given that I have not had the opportunity to closely review the training already provided I have decided that it may be useful to invite JHFMHN to send an email to all JHFMHN nurses who conduct RSAs or triage PSRFs reminding them of best practice in this regard. I do not intend to elevate this suggestion to a formal recommendation but trust, given Ms Sheehan's evidence, that my suggestion will be taken up.

Self-referral forms

117. Clearly the triaging of Kerry's self-referral form was a significant missed opportunity in the circumstances of this case. I note the JHFMHN quite properly accept that a review of Kerry's Alerts and active health conditions, together with a review of the JHeHS records

[71] JHFMHN Submissions at [6.6].

ought to have taken place on receipt of her form. Further JHFMHN accepts that a semi-urgent referral was indicated.

118. Counsel for the family suggested recommendations aimed at strengthening the processes around the triaging of self-referral forms. Firstly, by giving consideration to making it a mandatory requirement for nurses to make an entry into the patient's JHeHS progress notes whenever a self-referral form is triaged. Secondly, by making it mandatory to scan and upload any patient self-referral form into the patient's medical record.

119. Counsel for JHFMHN drew the courts' attention to the evidence of Ms Sheehan and to policy attached to her statement[72] disclosing that it is already JHFMHN policy that an entry will be made in the Progress Notes section of the Health Record acknowledging receipt of the self-referral form. In *practice* the receipt of the form and reason for referral is noted in PAS, which is then provided to the reviewing clinician. It should be noted that the entry on the PAS is in summary form. As counsel for the family pointed out, in the example before this court it did not capture the urgency of Kerry's complaint, namely "*I can't sleep, I can't eat. I'm slipping back".*

120. Dr Spencer informed the court that the PAS entry and the self-referral form are part of the patient's clinical records.[73] After a patient is seen by the clinician in response to a self-referral form, a clinical note setting out the complaint, treatment and plan is contained within the e-progress notes.

121. It was submitted that a duplicate entry in the JHeHS progress note merely noting the receipt of a self-referral would not necessarily improve patient safety in any obvious way. However, given that it might be some considerable time after the original self-referral form had been submitted that the clinician's response and treatment plan were recorded, the addition of the actual form may be of benefit.

122. JHFMHN stated that self-referral forms are "generally" contained within hard copy files for each patient. In my view, given the often lengthy waiting time before a clinical appointment might be made, it would be preferable to have a hard copy of the self-referral form scanned and uploaded so that it forms part of the electronic record and is promptly available. I note Dr Sullivan's evidence that this is the practice in Victoria.[74]

123. For the reasons outlined above, I have decided to make a recommendation regarding the scanning of patient self-referral forms.

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[72] Vol 1 Tab 33B, Att A; Policy 1.362: Patient self-referral for Health Assessment in Adult Ambulatory Care Setting (Non urgent issues only) at [3].
[73] 7.4.22 at T25-35.
[74] 7.4.22 T63.27.

Relieving boredom and frustration

124. As outlined above, inmates in quarantine appeared to have limited access to reading materials and no access to courses or other initiatives. The court heard evidence about inmates being locked down for 23 hours a day, and being frustrated that they were unable to access services as they usually would.

125. Counsel assisting suggested a recommendation directed towards inviting CSNSW to address the evidence of how bored and frustrated prisoners in quarantine are and consider what initiatives would alleviate boredom and engage prisoners better whilst they are in quarantine.

126. The Commissioner for CSNSW drew the court's attention to the '*Commissioner's Instruction 23/2022 2022 Novel Coronavirus (COVID-19) Interim Measure – Correctional centre management of quarantine and isolation hubs, fresh reception inmates and COVID-19 positive inmates*'. This instruction states that quarantined inmates will be provided with a range of materials and equipment to support their time during isolation such as a series of self-reflective and mindfulness activities drawn from the Explore, Question, Understand, Investigate, Practice, Succeed (EQUIPS) suite of programs.

127. Further the court was informed that custom configured secure tablets are currently being rolled out to inmates across the state. These tablets provide access to several diversionary activities, free games and various custodial-system account balances. The tablet will also offer the Offender Learning Management System, comprising online education. At the time of written submissions, the content was being workshopped with a view to being finalised by June 2023.[75] This roll out sounds promising but in my view further work could be done to ensure steps are taken in the short term.

128. Kerry's family further submitted that the court should consider a recommendation to the effect that CSNSW take steps to increase inmates' time out of their cells during quarantine.[76] The evidence before me suggested a review of inmate conditions under quarantine provisions may be called for.

Improving access to phone calls

129. There was some confusion about exactly why Kerry had problems using the telephone during quarantine on F Wing. However, as outlined above, the evidence was clear that Kerry was distressed at not being able to contact her loved ones, and that she repeatedly attempted to contact her daughter on the day of her death, to no avail.

[75] NSWCS Submissions at [35] – [41].
[76] Submissions of the family at p30.

130. Kerry's obvious concern was such that Correctional Officer Markanday took additional steps on 5 March 2021 to have Kerry's daughter's number activated.[77]

131. Following on from this evidence, Counsel assisting submitted that the court consider making a recommendation to CSNSW that allows inmates immediate access to phone calls for all prisoners as soon as they enter prison, and especially while housed in the quarantine area.[78]

132. Similarly, Kerry's family submitted that I consider a recommendation to CSNSW as follows:

That Corrective Services review its processes for providing access to phone calls to new receptions, in order to expedite the time within which inmates can freely use the phone system. This includes addressing delays in having numbers activated, and lack of credit to make phone calls. Consideration should be given to providing sufficient credit to inmates during their first month in custody to ensure that lack of funds does not limit their use of the phone system during that time.[79]

133. In response to these matters, CSNSW drew the court's attention to the evidence of Melanie Cameron, Acting Manager of Security for Custodial Corrections that:

" …typically, inmates will have phone access within the first 48 hours, however this is not always possible due to resourcing issues. If an inmate requires a phone call prior to being set up on the internal administration system, a request can be made to the Functional Manager of the relevant area. This request would certainly be granted if the relevant inmate expressed concerns for their family or had a serious personal issue…In addition, we also give consideration as to why a particular inmate doesn't have phone access, whether it is that they haven't got any money in their account, they haven't filled out the form, or the form has not been processed in a timely manner."[80]

134. Notwithstanding the matters raised by CSNSW, and the lack of clarity around exactly why Kerry had difficulties connecting with her daughter, it appears to me that CSNSW should look specifically at the access to telephone calls provided to quarantine inmates given the amount of time they appear to spend in their cells. No prisoner should ever be refused telephone contact through lack of funds or delays in processing forms.

Investigations

135. Kerry's family raised a number of concerns regarding the timely provision of statements

[77] 5.4.22 T81. 7- 82.4.
[78] Submissions of counsel assisting at 15.6.
[79] Submissions of the family at p30.
[80] Statement of Melanie Cameron dated 13 May 2022, page 3 [25] and [27].

during the coronial investigation and by reference to the timeframes set out in the court's First Nations Protocol and Practice Note No. 3 of 2021. It was submitted that the integrity of evidence is greatly affected by delays in witnesses making statements, including their ability to recollect critical details.[81] Kerry's family went on to suggest a number of recommendations to be directed to JHFMHN in relation to coronial investigations, including the following:

a) That Justice Health give consideration to whether it is appropriate to appoint a central liaison person to liaise with NSW Police in relation to the investigation of a death in custody, including in relation to identifying relevant issues and witnesses, and facilitating the provision of statements from Justice Health staff.

b) That Justice Health give consideration to amending its existing policy 1.120 "Management of a Death" to ensure that a written record is made as soon as practicable by nursing staff who are involved in the care and treatment of a deceased inmate in the period immediately preceding their death, and that this is reflected in the 'Nurses responsibility' at 2.2 of the policy.

c) That Justice Health review its current practices to determine how best to comply with the requirements of Practice Note 3 of 2021, and where necessary the First Nations protocol, in relation to identifying relevant issues and witnesses, and facilitating the provision of statements in a timely manner from relevant staff who were involved in the care and treatment of the deceased, whilst also protecting the integrity of any review under the Health Administration Act 1982, and the right of individual staff to obtain legal advice before preparing any statement.[82]

136. I do not intend to make the recommendations as outlined by Kerry's family, above. However, I do note that the court is considering a new practice note in relation to all health matters coming before the court. Such a practice note will give consideration to some of the concerns raised by Kerry's family. JHFMHN will be invited to participate in a consultation process during the development of that practice note.

Interagency Communication

137. Kerry's family raised concerns about the communication between CSNSW and JHFMHN regarding 'knock up' calls made by inmates. Knock ups are an emergency call system from cells directly to a CSNSW control room. Kerry's family highlighted that despite Kerry making a number of knock up calls on 4 and 5 March 2021 reporting medical concerns, there is no record of these being referred to JHFMHN by CSNSW. Indeed, the evidence revealed that

[81] Submissions of the family at p20.
[82] Submissions of the family at p29.

there is no requirement in the applicable CSNSW policy for any record to be made and kept.

138. In these circumstances, Kerry's family suggest that I consider making a number of recommendations on this topic:

a) That Justice Health implements a system for recording verbal requests from Corrective Services for attendance on an inmate in relation to a medical issue.[83]

b) That Corrective Services consider a revision of COPP 5.5 "Cell Security and Alarm Calls" and 13.2 "Medical Emergencies" to ensure that there is clarity around the situations in which Justice Health must be advised of a knock up call, given the lack of clarity in the existing policy.[84]

c) That Corrective Services review its processes to ensure that a record is made when there is a knock up call that requires attendance at a cell by Corrective Services, and/or a request to be made for attendance by Justice Health.[85]

d) That Corrective Services and Justice Health conduct a joint review to consider whether it is appropriate and necessary to create a system by which Corrective Services notify Justice Health of any health concerns or requests for attendance on an inmate, being a system that is not solely reliant on telephone contact, and which results in a written request being produced and transferred or shared between Corrective Services and Justice Health.[86]

139. CSNSW supported these proposed recommendations at paragraph 138(b), (c) and (d) above in principle, indicating that CSNSW would consult JHFMHN in this respect. Further, CSNSW would consider amending its' policy to clarify when JHFMHN must be advised of a knock up call.[87]

140. JHFMHN submitted that the evidence did not give rise to the recommendations proposed by the family as set out at 138 a) and d) above.[88]

141. Notwithstanding JHFMHN do not support the making of the recommendations proposed by Kerry's family but noting the particular issues arising in this case, it seems sensible to me to have a record of requests for medical assistance made by CSNSW to JHFMHN. It is clear that CSNSW and JHFMHN need to work together closely and cooperatively when

[83] Written submissions on behalf of the family, p29.
[84] Written submissions on behalf of the family, p30.
[85] Written submissions on behalf of the family, p30.
[86] Written submissions on behalf of the family, p30.
[87] Written submissions on behalf of the Commissioner of CSNSW, p11-12.
[88] Submissions on behalf of the Justice Health and Forensic Mental Health Network, p41.

inmates knock up for medical issues. It will be useful to review whether the communication between them can be clarified and improved. I intend to make a recommendation in relation to this issue.

Findings

142. The findings I make under section 81(1) of the *Coroners Act 2009 (NSW)* are:

Identity

The person who died was Kerry-Ellen (Nikki) Knight

Date of death

She died on 5 March 2021

Place of death

She died at Silverwater Women's Correctional Centre, Silverwater NSW.

Cause of death

Kerry died from hanging

Manner of death

Kerry was alone and locked in her cell when she placed a sheet around her neck and attached it to a shower rail, which was a prominent hanging point in her cell. Kerry had only been in custody for a short period and was subject to COVID-19 quarantine protocols. Her death was intentionally self-inflicted.

Recommendations pursuant to section 82 *Coroners Act 2009*

143. For the reasons stated above, I recommend:

To CSNSW

144. That immediate consideration is given to piloting and supporting a Peer Support Program (such as the Listeners Program) aimed at improving mental health support in custody. Further I recommend that the pilot commence at a womens' prison as soon as possible and progresses only with full consultation with JHFMHN in the planning, development and operation of the program.

145. That Cell 5 and other like cells in F Wing of Silverwater Women's Correctional Centre be refitted to remove hanging points or decommissioned as soon as practicable.

146. That further consideration is given to initiatives that would alleviate boredom and isolation for inmates kept in COVID-19 quarantine, including but not limited to allowing immediate access to telephone services (irrespective of financial issues), increased time out of cells and recreational activities.

147. That CSNSW review its processes to ensure that a record is made when there is a knock up call that requires attendance at a cell by CSNSW, and/or a request to be made for the attendance by JHFMHN.

To JHFMHN

148. That consideration is given to making it a requirement to scan and upload any patient self-referral form (PSRF) into the patient's electronic medical record.

149. That consideration is given to amending Justice Health Policy 1.225 "Health Assessments in Male and Female Adult Correctional Centres and Police Cells" to include at 3.2.1 a requirement for the nurse conducting the RSA to undertake a review of the medical records. The following wording could be considered:

> *Where possible, the RN or EN should undertake a review of any recent medical records held by Justice Health in relation to the patient, particularly in circumstances where the patient is not responding or communicative or where information received during the assessment is inconsistent with any active or inactive PAS alerts or health conditions.*

150. That JHFMHN review its processes for recording verbal requests received from CSNSW for attendance on an inmate in relation to a medical issue.

Conclusion

151. Kerry's death occurred when she was left alone for a short period of time in a cell which contained an obvious hanging point. There were a number of critical deficiencies in the care Kerry was offered in custody. Mistakes had already been made when undertaking her RSA and when processing her PSRF. Even more significantly Kerry's requests for assistance on the morning of her death did not result in prompt or useful action. In my view CSNSW were not given adequate information to properly assess Kerry's risk in relation to ongoing cell placement. While placed with another inmate Kerry had some protection. When that inmate was removed from the cell on the morning of 5 March 2021, she quickly fell into profound despair. Her death is a very significant tragedy and may have been preventable.

152. I hope that CSNSW work quickly to commence a pilot peer support mental health program for women. It could represent one positive outcome from this very tragic inquest. Kerry's family have engaged in this difficult process in the hope of creating change for other women in custody. I thank them for their participation in these proceedings.

153. I offer my sincere thanks to counsel assisting, Dr Peggy Dwyer and her instructing solicitor Ellyse McGee for their hard work and enormous commitment in the preparation of this matter and in these findings. I express my ongoing thanks to Nicolle Lowe for her tireless work in supporting families at this court. I also thank Senior Constable Ryan Tegel for his hard work during the investigation of this matter

154. Finally, once again I offer my sincere condolences to Kerry's family, especially her sister and children DK and ZC, and their families. I acknowledge their profound grief and respect their attendance at this court in the hope of creating change for other woman with trauma backgrounds who remain incarcerated today.

155. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
28 September 2022