CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of N J G
Hearing dates:	24 March 2022
Date of findings:	24 March 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody; cause of death is consistent with history of hanging; first time in custody and on remand; role of Justice Health and Forensic Mental Health Network
File number:	2020/20808
Representation:	Sergeant Howard Mullen, Advocate Assisting the Coroner Ms Szulgit, Justice Health and Forensic Mental Health Network Ms De Castro Lopo, Commissioner of Corrective Services
Findings:	I make the following findings pursuant to s81 of the Coroners Act 2009 NSW: Identity: N J G Date: 20 January 2020 Place: Metropolitan Remand & Reception Centre at Silverwater Cause of death - consistent with the history of hanging Manner of death –self-inflicted
Recommendations	Nil
Non-publication orders:	A non-publication order was made on application of Commissioner for Corrective Services

JUDGMENT

Introduction

1 This is an inquest into the death of Mr N J G, who at the time of his death was in lawful custody, being held on remand at the Metropolitan Remand & Reception Centre at Silverwater. Mr G died on 20 January 2020. He had been remanded in custody from 3 October 2019. This was the first time Mr G had spent time in custody in a correctional facility.

2 As Coroner I offer my condolences to the family of Mr G, for their loss. Mr G's family members include his wife Ms KG1 and their children; and family members from his first marriage to Ms KK, being his daughter, and step daughters. The death of a family member is deeply saddening, and this can be made more difficult in circumstances where the death was unexpected.

The role of the Coroner

3 The purpose of an Inquest is to investigate how and why a person died, and to find ways, if possible, to stop preventable deaths.

4 It is the role of the Coroner to investigate and make findings about sudden, violent, suspicious or unnatural deaths. Findings are required to be made in relation to:

(a) the identity of the person who has died,

(b) the date and place of the person's death,

(c) the cause of death, and

(d) the manner (or circumstances) of the person's death.

5 Recommendations may also be made where appropriate: s82 of the Act gives the Coroner the power to make recommendations concerning any public health or safety issues arising out of the death in question, and to find ways, where possible, to stop preventable deaths.

6 As Mr G died whilst in custody, this is a mandatory Inquest in compliance with section 27 of the Coroner's Act.

7 When someone is in lawful custody they are deprived of their liberty and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

Background

8 At the time of his death, Mr G was married to Ms KG1. This was his second marriage, and as a result of this marriage he had two children, KG2 and MG. It is clear from the statement provided by Ms KG1, as well as the numerous phones calls and letters between the two, that Mr G and Ms KG1 were in a loving relationship. Mr G was also survived by his brother DV, and sister-in-law, BL.

9 Mr G was previously married to Ms KK. As a result of this relationship, he has a daughter, BB. Mr G also has two stepchildren, who were from Ms KK's previous relationship. From the children and the stepchildren, there are fourteen grandchildren.

10 Prior to his arrest and subsequent death, Mr G could be described as financially stable and in good physical health. He was employed fulltime, had a small mortgage and no other significant debts.

Custodial History

11 On 3 October 2019, Mr G was arrested. He was refused bail by the Police and subsequently the Courts. Mr G was transferred into Corrective Services New

South Wales and housed at the Metropolitan Remand and Reception Centre, Silverwater. He was in a cell with two other inmates.

12 At the time of his death, Mr G was being held on remand for offences relating to aggravated sexual assault of a child under 16 years. Aside from these charges Mr G had no criminal History.

The inquest

13 Given that Mr G was in custody at the time of his death, a mandatory inquest is required under the Coroners Act 2009 NSW.

14 At the hearing, the officer in charge of the police investigation, Senior Constable Adam Davis, gave evidence. The police brief of evidence was tendered in the inquest proceedings.

The evidence

15 The evidence consisted of the oral evidence of the officer in charge of the investigation, and the brief of evidence.

16 The brief of evidence reveals that the investigation by the police was detailed, and the police brief included a number of records, documents and witness statements. Witness statements included those obtained from: investigating police; custodial officers; five Justice Health nurses/staff who attended to assist Mr G at the time that he was found in his cell on 20 January; a detailed statement was provided by his wife Ms KG1; statements and incident reports were obtained from Correctional Officers. Other witness statements and documents included: records of interviews with the two other occupants of the cell, Mr J and Mr Gr; a video statement with two other inmates- namely, Mr W and Mr B; crime scene photographs; 000 recording transcripts; Justice Health records for Mr G; New South Wales Corrective Services documents for Mr G including file records; New South Wales Corrective Services investigation report; statements and incident reports from Correctional Officers; the phone call activity report for phone calls made by Mr G while he was in custody; New

South Wales ambulance records and ambulance officers statements; transcripts of gaol telephone calls; letters written by Mr G; body worn video footage by Correctional Service officers; CCTV footage from the cell block, pod 16.

17 The autopsy report and the initial report of the death to the Coroner, being the P 79A document, were also in evidence.

18 It is worth commenting that the police actively and thoroughly investigated the death of Mr G including taking forensics swabs from his two cellmates for analysis, and conducting a thorough investigation of the scene of Mr G's death, being his cell. All possible evidence such as CCTV footage and call records, body worn footage and Corrective Services and Justice Health records were obtained and examined by investigating police, and provided to the Coroner in the brief of evidence. This evidence will be referred to by me in these reasons for decision, but not all of the evidence will be summarised.

Medical History

19 The evidence in the police brief indicates that Mr G was in physically good health.

20 It was reported to investigating police, and also to health staff within the correctional system, that Mr G had no history of mental health diagnoses, nor previous mental health episodes.

21 The investigation into his death has revealed that Mr G had disclosed to Justice Health that he was feeling depressed due to his situation, he was offered counselling and it is noted that this helped, however this appears to be in contrast to what he told Ms KG1.

22 Ms KG1 stated in her statement to police that Mr G told her about seeing a psychologist but that he found little help in doing so and reported it to be a waste of time.

23 A review of Justice Health records obtained by the police during the Coronial investigation indicates that on initial assessments on 5 and 6 October 2019, Justice Health took health information from Mr G and did some screening tests. They noted it was Mr G's first time in custody, that he had a history of hypertension, that there were mental health issues and that he was cleared from Darcy mental health for a two cell placement – this assessment is dated 6 October 2019. On 5 October 2019 the Justice Health notes indicate there was a direction to monitor Mr G, given he was the first time in custody, so as to assess and address any health issues.

24 The medical records from the treating doctor of Mr G in the community were requested by Justice Health, and the request form for those records is dated 5 October 2019. At Justice Health triage, on 6 October 2019, the history of hypertension and headaches was noted. The reason for referral was stated as the nature of his charges, and that he was first time in gaol, and his medical issues and history of heartburn. It was noted he had no drug or alcohol abuse history and that he was in close contact with his wife. The mental state impression was "situational crisis". There were noted to be no current risk indicators and the overall risk of self harm was assessed to be low. However in the summary section it was stated:

> "patient's first time in gaol, feels he is at risk from violence from others due to the nature of the charges, patient says he is feeling 'depressed' due to the situation - given reassurance about being on "LA" category, patient settling with support and counselling from staff".

25 Mr G was then cleared from the mental health unit and approved for a two out cell placement.

26 The Justice Health notes indicate Mr G was regularly observed for symptoms of hypertension. A detailed progress/clinical note of 6 October 2019 details the reassurance and counselling provided on that date included information about the gaol system, and that he had been accepted as an "LA" patient. It was noted that:

> "he was initially teary and saying he was scared and depressed due to the situation, but after being given counselling he said the counselling had helped". [The note states-] "patient has no current medical concerns or mental health history. Patient presents as a situational crisis as he responded to counselling".

27 The assessment of 5 October 2019 by Justice Health indicates that in providing information to Justice Health in respect of most health conditions, Mr G reported that he did not have these, nor did he report substance abuse issues to Justice Health; on the mental health screening tool which Justice Health administered - the Kessler 10 scale – Mr G scored 10/50. This was a 'score which indicates the patient may currently not be experiencing significant feelings of distress'. It is clear that a social alcohol use was declared to Justice Health by Mr G, as was a history of hypertension, reflux, and this was kept under review. There was a multidisciplinary care plan, updated on 28 October 2019, for Mr G, in which it was noted that his hypertension needed to be regularly reviewed with blood pressure checks and review of medications - he was also seen for monthly risk assessment pack and was suitable for same – this indicates he obtained medications as required. It appears Mr G attended an immunisation clinic on 18 January 2020 when he was seen for his hep B vaccine and consented to administration of the vaccine. He waited in the clinic for 20 minutes post injection. Those notes do not indicate that any other condition was of concern during this clinic visit, or reported by Mr G to staff.

28 As detailed above Justice Health file notes observe that Mr G was placed under a monitoring role given his report of distress and hypertension and as he was first time in custody. The notes indicate that he was to be observed and monitored in respect to his mental health and his hypertension. He was seen often by Justice Health nurses in relation to his hypertension and the notes do not indicate that he sought any further help for his emotional well-being or his mental health. It is noted that he reported to his wife that he had seen a psychologist and that he found it to have been of no use to him, and a waste of time – this indicates that Mr G may not have requested further assistance, or engaged in further treatment, if offered. Further, the wish not to engage with the psychologist would appear to be consistent with his approach

to custody – the evidence indicates that he kept to himself, kept apart from other inmates mostly, and did not engage.

29 There are entries in the Justice Health file on 28 October and 9 November 2019 for monitoring of his hypertension and general health. The Justice Health notes contain two "Patient Self-referral forms" completed by Mr G. This evidences that Mr G was aware of the process for seeking further assessments and/or treatment from health providers within the gaol. The first of these forms is dated 15 October 2019 and asks for assessment for a medication issue, and a request to talk to the nurse, the reason given is severe heartburn. A second patient self referral form, dated 16 December 2019, states that he wishes to see health centre staff for "hurt/pain" and "talk to nurse". He writes in the reasons section of the form:

> "I have a hole in my back molar and the pain on the nerve is severe. I have spoken to dental and booked in but can't do anything until New Year. They advise to talk to you about pain relief. Also overdue for hep B vaccination for second shot thank you" .

30 As noted above he attended an immunisation clinic on 18 January 2020 probably in response to his request on this form – other evidence indicates he was distressed around this time about the separation from his wife due to his custodial situation but it does not appear that he disclosed it this at the clinic when he attended, nor in any 'Patient Self Referral Form".

31 As noted above Justice Health requested medical records from the treating doctor in the community. The health summary sheet received on 24 October 2019 by Justice Health, from the treating general practitioner in the community, is a record of Mr G's medical treatment in the community. It states his medications in the community, and his diagnoses. There were no current active problems recorded, and no significant recorded past medical history, but there was a history of medications. These appear to have been for his hypertension. There was nothing in those medical records from Mr G's doctor in the community which indicated a history of mental health issues, depression or anything to indicate a potential for self harm.

32 The evidence indicated that Mr G was distressed, and likely depressed, in response to situational stressors, namely this being his first time in custody, separation from his wife and family, in conjunction with the nature of the charges.

33 Those Justice Health records, as detailed above, indicate that on 6 October 2019, after a mental health triage, Mr G was cleared from the D'Arcy mental health unit and was housed in the Hamden Unit with two other inmates.

Events leading to his death

34 The police brief of evidence indicates that investigating police obtained all movement records, CCTV footage and other items to assess and evidence Mr G's movements prior to his death. On Monday, 20 January 2020 Mr G characteristically spent much of his free time queuing for or using the inmate telephone to contact friends, though predominantly his wife. Investigating Police reviewed the CCTV footage, phone calls and confirmed his actions.

35 Prior to going to bed, Mr G began to erect a sheet and said to his cellmates that if they hear him sobbing or making any noises, they should ignore it, as he was feeling sad and may be crying. Both the cellmates accepted this without question. In interviews the cellmates stated that for the last couple of days Mr G had been erecting a sheet and this was a way of obtaining privacy in the cell. As they experienced that Mr G was a man who often kept to himself, reading and also writing his letters, they did not question his need for privacy. Mr G told his cellmates not to worry if they heard him crying and given that he did sometimes cry they did not question this.

36 The cell mates tell police that after Mr G went to bed and the lights were turned off, they heard what they described as crying. Mr G was asked whether he was OK and he replied with a "yes" . On another occasion one of the cell mates visually looked at Mr G when he was making noises, and saw his arms moving about, and thought he was waving them away.

37 The cell mates stated that the noises were heard again, and so they asked whether Mr G was OK, there was no response, so they asked once more and still there was no response. At that point they were worried and went to see what was happening.

38 The cellmates tell police they got up and turned the lights on. It was at this point that they saw a ligature around Mr G's neck. It was clear Mr G was not breathing. The Knock up alarm was pressed, Corrective Services Officers and Justice Health staff members attended the cell and begun CPR which continued for approximately 20 minutes. Ambulance officers attended a short time later, and after conducting assessments, it was determined that Mr G was deceased.

Conclusions

39 There is no evidence to suggest that there was any third-party involvement in this incident. There is no evidence of any involvement of the other two cell occupants in Mr G's death. Indeed their accounts in the records of interview conducted with each man, were largely consistent with each other and with the evidence of the scene. The two men were also subjected to forensic testing and this did not yield any indication of their involvement.

40 The evidence reveals that Corrective Services Officers and Justice Health staff responded once the alarm was raised by Mr G's cell mates. They took appropriate actions to try to revive Mr G when they arrived at his cell, and the ambulance was called and attended.

41 The evidence indicates that the other two occupants of the cell did raise the alarm to obtain help. They respected Mr G's privacy but even so asked after his welfare when they heard him crying, and when they heard further noises. He said he was ok initially, and on their second inquiry he appeared to wave them away, but on further noises they did turn on the light and found him and raised the alarm. Tragically, by then it was observed that he had ceased breathing and was unable to be revived by Corrections Officers and Justice Health staff and ambulance officers who attended.

42 The remaining issue is whether Mr G's state of mind should have been diagnosed by Justice Health and/or more protective measures/treatment undertaken in the weeks prior to his death. I note the records, which I have detailed above in these reasons for decision, indicate that Mr G was seen several times by Justice Health nurses who were monitoring him, and in particular monitoring his hypertension. After the initial screening in early October 2019, despite continuing contacts with Justice Health nurses, it does not appear that Mr G, during any meeting with nurses or any clinic attendance, sought help for his state of mind, or reported his symptoms. Nor is there any evidence that any inmate reported any concern about Mr G's wellbeing to Justice Health. Mr G told his wife that he was referred to a counsellor, a psychologist. According to material contained in the brief of evidence, he reported to his wife about seeing the psychologist at Silverwater:

> He told me that he saw a woman and that it was a waste of time. She told him that there are a lot of topics she could not discuss with him. She told him that he would need to assimilate. He was annoyed and said he didn't want to assimilate as he shouldn't be there. He said there was no point speaking to her because she couldn't help him".

43 Given Mr G's reported experience of the psychologist, he may well have been unlikely to have requested further treatment.

44 There were no records of concern in the health records from the community sent to Justice Health Further, Justice Health did conduct an assessment of his distress (as summarised above) and this indicated low risk – for these reasons Justice Health would not necessarily have been aware of a potential for self harm by Mr G. Mr G, both in his personal presentation to Justice Health and his clinical history did not have indicators of risk of self harm - he had no history of diagnosed mental health conditions, no history of self harm attempts, no prescribed psychiatric medication, no history of being prescribed anti-depressants, no substance use history, no history of abusing illegal drugs. Those features can be indicative of heightened risk of self harm for someone in custody, but these were not present in Mr G's case and the clinical assessment of his risk in early October 2019 indicated low risk. It was acknowledged by Justice Health at that time that there was some risk given

that it was the first time he had been in a custodial situation, and because he was experiencing situational stressors upon reception into custody, but that risk was assessed as low risk on his presentation after receiving counselling. Justice Health maintained a status of monitoring Mr G after the initial assessment.

45 Descriptions of Mr G by other prisoners such as Mr W and Mr B indicate that he kept to himself. Mr W was probably the only person to really interact with Mr G and he certainly described him as being tearful and upset about being in gaol and missing his wife.

46 The police brief of evidence details that Mr G was a prolific letter writer - during the time he was incarcerated he mailed 48 envelopes containing letters to friends and family members, 31 of which were with written to his wife, KG1. Most of the envelopes contained multiple letters written over a period of several days before being mailed together. Date stamps on the envelopes gave a clue to the order in which they were posted. In the view of investigating police the letters provided an insight to the emotional and mental state of the deceased. The letters to family and friends were often expressing thanks for their cards and letters and their words of encouragement. The letters to his wife, KG1, were more emotive and gave more insight into his mental and emotional state. Some of the letters were adorned with hand drawn images probably the work of fellow inmate Mr W. The letters confirm that Mr G kept to himself "I don't mix with anyone but I am polite" "I feel safe-ish but am very wary"..

47 He wrote to his wife, KG1:

> "my concerns are you and only you. This load of bullshit we are going through is, I'll get straight to the point. The way the law is that I hear listening to conversation is not designed for the accused in no way. This is going to cost a lot of money as I have said in past letters with no guarantee if any of me getting off..... Apart from the legal cost which will have to pay when I lose and if I do lose, maybe will be sued, I'm not sure. My concern is losing most of what we have worked for. We have worked hard for what we have and I in no way want to have you struggling in the future. I have to put some thought into how to stop this from happening. I am no use to you in here. I'm

> beginning to lose faith in this system. I have nothing else to do but think, my head is all over the place but one thing I am sure of is I love you xx"

48 The letter quoted above was dated 7 January 2020 but the envelope which contained it was not postmarked until 21 January 2020. The time difference, in the police view, was likely a combination of the deceased delaying sending some letters to include multiple letters in a single envelope, and a delay caused by the mail system within the prison and Australia Post. An envelope which was postmarked 23 January 2020 contained six letters. This was received by KG1 following Mr G's death. The police brief states that the letters, in the opinion of the officer in charge of the investigation, provide Mr G's final wishes for the allocation of some of his sentimental belongings and provide final thoughts and words on his incarceration and the allegations against him. One of the letters states:

> "to pay for legal is no guarantee of proving this accusation wrong and being locked up, I am no use to you away from you anyway. I will not leave you without the security we have worked for, I will not see you struggle. My head is everywhere and find myself writing several letters instead of just one. I don't have much faith in system.….I'm distressed at the thought of losing our children and my life as I know it before this bull shit. I want you to enjoy your life when it all settles down and don't settle for anything. Make sure it is perfectly what you want. Don't let anyone take what we have worked for. I give my all for you. I love you. N"

49 Another letter states:

> " I am not going to let us lose what we, you and I have worked very hard for to give away to a lawyer, barrister. If I fight this we have to pay. Security if I get bail, pay barrister with no guarantee of winning. Putting a decision in the hands of people that are picked to go against me and if I lose be locked up for who knows how long so we have paid for nothing and I'm no good to you and I will not be locked up, I'm hanging by a thread in here anyway, I can't put into words what it feels like. Our family has gone to shit because of this, I won't get to do the family things with our grandkids and I don't want this taken from you" .

50 In another letter he says how much he loves KG1, and gives thanks:

> "you are the breath in my life my beautiful wife. You gave us our family and made our house our home. You are the happiness in my life…… I thank you and the universe for our time together."

51 In her statement to police KG1 provides her view of the letters, with which the officer in charge agrees. She stated, in respect to letters which she received in the week after Mr G's death:

> "The contents of the letters are pretty confronting. From reading the letters it is clear to me that N saw no way out of the allegations. In the letters he gave me his final wishes for me to deal with some of his property and what financial things I need to sort out. He indicated some of his belongings and detailed who I should give them to. He wrote down three songs which I interpreted as being the songs that he wanted played at his funeral. The letter showed that he didn't have any hope for being cleared and he repeatedly stated he did not do what they accused him off. He told me in the letters that we worked hard for everything that we have obtained and that he didn't want it taken away by lawyers and barristers in legal fees. He stated he wouldn't get to have the memories of playing with his grandchildren but that I should be able to enjoy it. He wanted me to be happy. He stated in one letter that what he was going to do was not an admission of guilt. I think the letters clearly show he intended to take his own life"

52 The evidence supports a conclusion that Mr G felt hopeless about the potential outcome of his court hearing; the cost of legal representation; what he perceived as the likelihood of conviction and gaol term; and that he expressed a motivation to preserve his wife's financial security. Whilst there is no doubt he was distressed by being in custody and his mental state was affected, it is not clear on all the evidence that this would have been apparent to Justice Health. I note Mr G's view that a psychologist could not help him, and accordingly he was not motivated to have further engagement with a psychologist. I also note that he kept to himself according to inmates, and he did not ask for help from Justice Health nurses when he saw them. This makes it probable that Justice Health were not alerted to any increased risk or a need to take any action.

53 Given that Justice Health had put on his file that Mr G was to be monitored for mental health and hypertension, and that nurses were seeing him regularly, I am unable to find, having regard to all the evidence, that Justice Health failed to care for Mr G. Mr G's phone communications and letters show that he evolved a point of view that his legal case was hopeless, that he was likely to have a lengthy gaol term, that he wished to avoid that eventuality, that he wanted to avoid the costs of contesting the case, and he wanted to protect his

wife's future well being. He was concerned to ensure that his wife, KG1, was financially provided for and that he not erode this. Whilst it was very clear that he knew that his wife, KG1, loved him and was standing by him, and fully supporting him, he remained concerned on her behalf.

54 Ms KG1 also raises issues of why her husband was refused bail, these are matters which were within the judicial function of the Local Court and I observe that it is not unusual for persons charged with serious offences to be refused bail. The Officer in Charge gave evidence that Mr G was charged with a "show cause" offence – this is an offence for which the Bail Act provides that an accused must be refused bail unless he shows cause why his detention is not justified. The bail papers from the Local Court indicated a reason for refusing bail was that he had not shown cause. On all the evidence in this case, the bail decision is not a matter for further inquiry in this coronial inquest. I do observe for completeness that further applications for bail may be made to the Supreme Court, and if there is a change in circumstances a further application for release on bail can be made in the Local Court. It appears that making a further release/bail application was under consideration but that had not yet occurred.

55 Ms KG1 also raised the issue that Mr G was falsely accused (leading to the charges) but that is a matter which, on the circumstances of this case, was for determination by the criminal courts and is not a matter for coronial inquiry at this inquest.

Cause of death

56 On 24 January 2020, a postmortem was conducted on Mr G, by Dr Elsie Burger, with the direct cause of death being determined to be consistent with the history of hanging. The Senior Staff Specialist Forensic Pathologist who conducted the post-mortem examination and prepared the autopsy report, made several examinations including post-mortem full body CT scans; toxicological analysis of preserved blood; external examinations. The forensic pathologist observed that the facial skin of the deceased, as well as his eyes,

showed signs consistent with the history of hanging. There were also limited identifiable changes on the skin of the neck. There is clear demarcation where the haemorrhages of the face started and the pathologist also examined the alleged ligature, and its appearance was not inconsistent with the marks observed. The CT scans of the body did not show any significant abnormalities or injuries. The toxicological analysis did not show any foreign substances. The pathologist was satisfied that the cause of death was consistent with the history of hanging. The pathologist did not find any suspicious injuries and the only injuries observed were a small crust on the left lower leg and two small skin lesions on the right thumb, neither wound appeared acute. The only other injuries observed were to the neck and were consistent with hanging. I am satisfied that the pathologist's opinion should be accepted as it is supported by the other evidence in this matter, obtained during the police investigation.

Manner of death

57 As noted above there is no evidence of third party involvement in the death of Mr G. There is no evidence of any involvement of the other two cell occupants in Mr G's death. There is also no evidence to suggest that any action or omission by either Corrective Services or the Justice Health and Forensic Mental Health Network, at the point when he was discovered in his cell, contributed to Mr G's death in any way. There was no lack of care provided to him at the time of his death.

58 Ms KG1 has questioned whether Mr G's state of mind was adequately diagnosed and whether he was appropriately cared for in custody. When a person is lawfully detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State, so it has been important that I carefully consider this issue in this inquest. I have reviewed the evidence relating to his assessment and treatment by Justice Health in these reasons for decision. In the Conclusions section I have detailed my findings of fact on this issue and my reasons for making these findings.

59 As explained above, the Justice Health records indicate that his medical history was sought from his treating doctor in the community, and apart from hypertension, it raised no issues of concern in relation to mental health or self harm. Mr G's self report to Justice Health of his medical history was consistent with this. The notes of his mental state due to "situational crises" are set out above and include the results of the administration of the Kessler scale. On all of those records it was reasonable for Justice Health to have made the assessments made.

60 In addition Mr G did not report his state of mind to Justice Health after early October 2019 despite many opportunities given his ongoing engagement with Justice Health who were monitoring Mr G's hypertension. The letters and phone calls from Mr G indicate that he had decided that his legal case was hopeless, that he was likely to have a lengthy gaol term, that he wished to avoid that eventuality and the costs of contesting the case, and wanted to protect his wife's financial well being. The evidence indicates that he loved his wife KG1 very much and she loved him. It appears clear that he knew she would stand by him, but he made a decision to end his own life, based on those views about his situation that he held. I find that he placed a ligature around his neck with the intention of taking his own life, and the manner of death is self-inflicted.

FINDINGS

61 The findings I make in relation to the deceased, under section 81(1) of the Act are:

Identity: Mr N J G

Date: 20 January 2020

Place: Metropolitan Remand and Reception Centre at Silverwater

Cause of death: consistent with the history of hanging

Manner of death: self-inflicted

Closing

62 I acknowledge and express my gratitude to Sergeant Howard Mullen, Coronial Advocate Assisting the Coroner, for his assistance both before and during the inquest. I also thank the Police officer in charge, Senior Constable Adam Davis, for his work in the Police investigation and compiling the evidence for the inquest.

63 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr G's family.

64 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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