CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of CJ
Hearing dates:	28, 29 March 2023
Date of findings:	6 June 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-death in custody- mandatory inquest-adequacy of treatment and care-opportunity for family to raise concerns about the welfare of inmates and patients while they are in custody-telephone calls by inmate to protected person in Apprehend Violence Order
File number:	2021/2579
Representation:	Mr C Gardiner, Counsel Assisting instructed by Mr G Martin, Crown Solicitor's Office Mr D Barrow, instructed by Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Mr H Norris representing Justice Health and Forensic Mental Health Network Ms S Idowu of Hall and Wilcox representing St Vincent's Correctional Health Mr T Hackett instructed by Mr S Bailey of Ingenium Legal representing MTC Broadspectrum

Findings:	I find that CJ died on 31 December 2020 at Bathurst Correctional Centre, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.
Recommendations:	**To the Chief Executive, Justice Health and Forensic Mental Health Network:** 1. I recommend that the Justice Health and Forensic Mental Health Network ("Justice Health") make it clear on its public-facing web page, that the Justice Health Mental Health Hotline does not operate in respect of inmates held at Parklea Correctional Centre and that the contact details regarding the mental health of inmates at Parklea Correctional Centre should be provided. **To the Chief Executive Officer, Management & Training Corporation Pty Limited:** 1. I recommend that Management & Training Corporation Pty Limited ("MTC") implement changes to its website to make clear that members of the public who have concerns about the mental health of an inmate at Parklea Correctional Centre should contact MTC rather than Corrective Services NSW or the Justice Health and Forensic Mental Health Network. They should provide a direct link to the appropriate number, and it should all be on the front page of its public-facing website.
Non-publication orders:	That pursuant to s. 75(1) of the *Coroners Act 2009* there is to be no publication of any information that identifies or may tend to identify the deceased or any member of his family. Other orders have been made in this inquest under s. 74(1)(b) of the *Coroners Act 2009* prohibiting the publication of certain evidence. The orders may be found on the Registry file.

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the tragic death of CJ who was born on 10 December 1963. CJ sadly took his own life on 31 December 2020 while he was in lawful custody at Bathurst Correctional Centre.

2. The role of a coroner is to make the following findings that are required by s 81(1) of the *Coroners Act 2009* ("the Act"), namely:

    i. the identity of the deceased;

    ii. the date and place of the death; and

    iii. the manner and cause of the 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. The Act requires a senior coroner to conduct an inquest where a death occurs in custody. In such cases the community has an expectation that the death will be properly and independently investigated.

5. This inquest is not a criminal investigation, nor is it civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. The primary focus in this inquest is whether there are any lessons that can be learned from CJ's death and whether anything should or could be done to prevent a similar death in the future.

6. Pursuant to section 37 of the Act a summary of the details of this case will be reported to parliament.

CJ

7. CJ was one of four children. He was a father, a grandfather, an uncle, and a cousin. He grew up on Lake Macquarie. He was very good at all sports. He played soccer and football. He was always working on cars and had a great mind for all things mechanical. He spent summers swimming,

sailing and he was a keen fisherman. He developed an interest in boats and followed in his father's footsteps as a shipwright repairing wooden and fibreglass boats and yachts.

8. On 18 June 2020, CJ's son took his own life. CJ was present on the scene shortly after the event and attempted to resuscitate him. His son was his best friend. His life then spiralled out of control.

Custody

9. On 16 November 2020, CJ was refused bail in relation to a number of domestic violence charges. He was firstly held at the Newcastle Court Cells and on the following day he was transferred to Kariong Intake and Transit Centre before arriving at Parklea Correctional Centre on 18 November 2020. CJ remained at Parklea Correctional Centre until 13 December 2020 when he was transferred to Bathurst Correctional Centre where he remained until his death. The period of custody leading up to CJ's death totalled 45 days.

10. This was not CJ's first time in custody. However, the longest period he had been held in custody prior to this was 8 days in late 1996.

11. The NSW Police Custody Management Record of 16 November 2020 indicates that CJ suffered from anxiety and depression but was not medicated or treated. No self-harm concerns were noted.

12. During CJ's incarceration at Parklea Correctional Centre, it was managed and operated by a joint venture ("MTC Broadspectrum") between Management & Training Corporation Pty Limited ("MTC") and Broadspectrum, with St Vincent's Hospital Sydney Limited contracted to provide and operate the primary health care service, St Vincent's Correctional Health. Since 1 October 2022 Parklea Correctional Centre has been operated and managed by MTC.

13. Bathurst Correctional Centre is managed by Corrective Services NSW with health services provided by the Justice Health and Forensic Mental Health Network ("Justice Health").

Screening and assessment

14. On 19 November 2020, whilst CJ was at Parklea Correctional Centre, an Intake Screening Questionnaire ("ISQ") and Health Problem Notification Form ("HPNF") were completed. The ISQ recorded that CJ had a history of depression and drug issues. It further recorded that CJ disclosed that his son had died by suicide in May 2020, which made him visibly upset when discussed. CJ denied any self-harm intention and declined referral to a chaplain stating that he "*was not ready*

to open up". The ISQ goes on to record that CJ was "unable to think of anything positive for the future".

15. The HPNF recorded: "*MH hx – self managing – good coping skills*" and "*Observe for agitation, mood swings, isolative/withdrawn behaviours*." It also noted that CJ had no thoughts of self-harm or suicidal ideations and guaranteed his own safety.

16. No referrals for any psychological services were made.

17. At Parklea Correctional Centre, inmates have 24-hour access to mental health services provided on-site by St Vincent's Correctional Health. The service includes:

    i. a general practitioner between 8:00 AM and 4:00 PM, Monday to Friday, and a consultant psychiatrist as necessary for review;

    ii. a mental health nurse 24 hours per day, seven days per week; and

    iii. nursing staff between 8:00 AM and 9:30 PM, seven days per week.

18. St Vincent's Correctional Health staff are responsible for ongoing nursing and medical monitoring to identify patients at risk of self harm. Trigger points for that monitoring and prioritisation of mental health management include:

    i. mandatory screening from the primary mental health team when a custodial patient returns from a court hearing;

    ii. patients presenting with mental health concerns;

    iii. patients who approach primary health care nurses for assistance during the daily medication rounds;

    iv. patients who complete a self-referral form seeking review; and

    v. an adverse event onsite which may compromise a patient's ability to cope.

19. As part of the primary mental health management, St Vincent's Correctional Health's nursing and medical staff provide daily clinics in various specialities including mental health. The mental health clinic operates seven days per week from three locations: the Main Clinic, the Area 4 Clinic and the Area 5/6 Clinic. The clinics are staffed by members of the mental health team including a combination of either the psychiatrist and a mental health nurse, a mental health nurse

practitioner or a mental health nurse. A 24/7 roster ensures a mental health nurse is always on duty.

20. External stakeholders can escalate patient concerns via mental health referrals from:

    i. correctional and non-custodial staff who identify that a patient requires review;

    ii. the Corrective Services Support Line;

    iii. the correctional service Official Visitors Program; and

    iv. family members or legal representatives, either directly to St Vincent's Correctional Health or via MTC.

21. St Vincent's Correctional Health also provides all patients access to self-referral forms which can be completed and submitted at any time. The self-referral form is triaged by the nursing team and subject to need, the patient is then placed on the relevant clinic waitlist through the Patient Administration System. Custodial patients receive information about the progress or outcome of their self-referral form through a feedback slip. The feedback includes whether an appointment has been booked or if the patient's name has been added to a waitlist.

22. In addition to the services provided by St Vincent's Correctional Health, MTC provides:

    i. an on-site psychologist to which inmates can be self-referred by request to any employee at Parklea Correctional Centre; and

    ii. a rapid response service for inmates requiring triage, assessment, and treatment for mental health matters.

23. Inmates are informed of the on-site mental health services during their induction. They can access these services by contacting staff on their cell's stenofone, contacting staff directly, requesting an appointment through the health referral procedure, or by asking the nurse on the daily pill round.

24. On 2 December 2020, CJ denied any thoughts of self-harm or immediate concerns in an interview following a Local Court appearance by AVL.

25. On 13 December 2020, on his transfer to Bathurst Correctional Centre, CJ again denied any current thoughts of self-harm or suicide.

Cell placement

26. In certain circumstances an inmate will be required to share a cell with another inmate (known as 'two-out'). In other circumstances an inmate will occupy a cell alone (known as 'one- out'). Generally, an identified risk of self-harm will require a 'two-out' placement. 'Normal' cell placement places no restriction on an inmates' accommodation arrangements.

27. Correctional centres use a cell card colour system to assist in quickly identifying inmates with management concerns. A cell card is placed on the wall or door immediately outside the inmate's cell. The colour of the card indicates an inmate's placement. The exact colour code varies between correctional centres. At Bathurst Correctional Centre two colours are used – white for 'normal' cell placement and green for inmates who must be 'two-out'. Inmates who must be 'one-out' have a white card with 'one-out' written on it.

28. The HPNF cleared CJ for normal cell placement. As such, CJ had a white cell card. His cell placement remained the same for the duration of his time in custody.

29. Up until 30 December 2020, CJ shared a cell with another inmate. However, on that date, CJ's cellmate was moved to another cell, and CJ was housed in his cell alone.

Events of 30 and 31 December 2020

30. On 30 December 2020, about 3:20PM, correctional officers were performing lock-in duties inside B Wing on the middle landing.

31. The correctional officers saw CJ in his cell and said words to the effect: "*All good bud*" to which CJ replied: "*Yeah chief*". The correctional officers closed the door and locked it. One of them looked through the peep hole and saw CJ standing up and okay.

32. Between lock-in on 30 December 2020 and let-go on the morning of 31 December 2020, no one entered or left CJ's cell. At about 12:22AM two correctional officers walked past CJ's cell but did not look inside.

33. On 31 December 2020 at about 8:24AM, correctional officers conducted the let-go of B Wing. When CJ's cell was opened, he was found hanging from a bedsheet.

34. The correctional officers radioed for medical assistance. Additional correctional officers also attended to assist. The bedsheet was cut to release CJ's body. The correctional officers checked for a pulse but found no signs of life. Resuscitation efforts commenced.

35. At about 8:27AM, Justice Health staff arrived. At 8:31AM Justice Health declared CJ life extinct, and preparations were made to secure the cell as a crime scene. NSW Ambulance attended the scene at about 8:40AM and departed shortly afterwards.

36. NSW Police arrived at 8:57AM and commenced their investigation.

37. A handwritten note was found in the cell signed by CJ and dated 30 December 2020 at 6PM.

38. An autopsy was performed on 6 January 2021 by Dr Alison Ward under the supervision of Dr Allan Cala. The examination identified the direct cause of death to be "*neck compression*" with the antecedent cause to be "*hanging*".

Phone Calls

39. During his period in custody, CJ frequently spoke by phone to a friend and to his wife, despite conditions of an Apprehend Domestic Violence Order prohibiting contact with his wife. He bypassed the limits on the telephone system to contact his wife by having telephone calls facilitated by his friend, and using a pseudonym for his wife.

40. All phone calls made by inmates are recorded. These recordings offer some insights into CJ's state of mind in the lead up to his death. Many of the calls were emotionally volatile.

41. On 17 December 2020, CJ told his friend and his wife that he went to see the chaplain and he was not coping with being in gaol. She offered to ring welfare to arrange assistance for him, however he told her not to as he did not want to be taken off his 'white card'.

42. Although CJ claimed to have seen the chaplain for assistance, it does not appear this occurred.

43. On the day he died, 30 December 2020, CJ was very angry during a telephone call with his wife. He told her that his cellmate was stealing food and he wanted to punch him.

Independent Expert psychiatric review

44. Doctor Danny Sullivan, Consultant Forensic and Adult Psychiatrist, reviewed the coronial brief which included all of the agencies' records. His opinion was sought in relation to the issues raised in this inquest.

Issues

To what extent were risks of self-harm apparent from CJ's history or presentation upon entering custody?

45. In his oral evidence, Dr Sullivan indicated that there are no validated or reliable statistical instruments to screen for self-harm risk. Risk assessment tools can assist in taking a structured history and ensuring that all relevant risk factors are considered but cannot combine these factors in any statistically meaningful way to predict which of the population might go on to attempt or die by suicide. Dr Sullivan's report noted that the most prominent evidence based clinical risk factors for suicide in prison are: recent suicidal ideations; history of attempted suicide; history of self-harm; current psychiatric diagnosis; depression diagnosis; psychotropic medication; alcohol misuse; and poor physical health. The contribution each individual risk factor makes to the overall risk is relatively little.

46. Dr Sullivan identified a history of self-harm attempts and expressed self-harm ideation as prominent risk factors that are more predictive of risk than other factors. People who have attempted self-harm have a lifetime elevated risk of dying by suicide, and expressions of self-harm ideation represent a level of distress which warrant some form of clinical escalation.

47. When asked to consider a situation where a person with no history of attempted self-harm or expressions of self-harm ideation presents with other risk factors, Dr Sullivan emphasised the significance of a patient's clinical presentation in the assessment of risk, and the availability of effective treatment options to mitigate the risk.

48. At the time of his reception screening, CJ denied thoughts of self-harm or suicide and no history of self-harm or attempted suicide was apparent. In terms of factors present which might indicate an elevated risk of self-harm or suicide, there were: the recent death of his son by suicide; the nature of the charges he was facing at the time being indicative of relationship difficulties; and a history of depression.

49. In his assessment of these risk factors, Dr Sullivan observed that people entering custody are likely to exhibit multiple risk factors, making reliance on any particular risk factor difficult. It was ultimately Dr Sullivan's opinion that the combination of risk factors present in CJ's case did not warrant clinical intervention.

50. Dr Sullivan further observed that the risk factors present in CJ's case did not point to a specific clinical intervention. In his oral evidence he said:

"Unfortunately, there are no interventions which will undo the risk factors or reduce their impact so for instance, we know that people who have suffered traumatic events may benefit from some form of counselling or psychological intervention. But we also know that imposing that intervention on a person who does not wish to have it, brings no benefit and may in fact exacerbate distress".

51. It was Dr Sullivan's view that there was limited information available to suggest that CJ was suffering from a clinically significant depressive illness. It is likely that he was experiencing an adjustment reaction which is common in people remanded in custody. Dr Sullivan did not consider CJ's distress at his son's suicide as being protracted or abnormal, but rather a normal reaction to the trauma of the event.

52. Ultimately, Dr Sullivan opined that CJ's presentation, on the information available, did not warrant any increased intervention. Many inmates will display a similar combination of risk factors which place them in an escalated risk category, but as the base rate of suicide is low, the presence of such risk factors adds little predictive value to a person's risk of suicide.

53. Dr Sullivan was asked to consider the evidence concerning the telephone calls between CJ and his wife, and the extent to which it might contribute to the assessment of risk. He described the content of the telephone calls as demonstrating some marked emotional lability and variability, and as including intimations of self-harm and, at various times, expressions of suicidality. However, he did not consider the intimations of self-harm or suicidal ideation to appear sustained or significant.

54. Significantly, Dr Sullivan did not consider it likely that knowledge of the telephone calls would have significantly altered an appraisal of suicide risk, unless on further questioning CJ disclosed suicidal ideation. Dr Sullivan elaborated in his oral evidence, stating:

"Obviously this is speculative, but one has to distinguish between statements which are throw away threats, threats that are taken as an expression of anger or emotional dysregulation as opposed to threats which are taken as a clear statement of intent. Given that the complex and often conflicting emotional tone of the conversations as reported in the brief of evidence, it's difficult to determine whether this would have led to a change in action".

Dr Sullivan went on to reinforce the significance of any subsequent clinical assessment in determining whether such statements are expressions of intent.

What were the reasons for CJ being placed in a cell alone? Was this placement appropriate in the circumstances?

55. CJ appears to have been housed 'two-out' during his time in custody, at Parklea Correctional Centre and Bathurst Correctional Centre, until 30 December 2020, at which time his cell-mate was moved to another cell and he was housed 'one-out', alone.

56. CJ was cleared for 'normal' cell placement during screening at Parklea Correctional Centre. As discussed earlier in these reasons, a 'normal' cell placement permits an inmate to be housed 'two-out' or 'one-out'. Accordingly, no change to CJ's cell placement status was necessary to facilitate this change in his accommodation on 30 December 2020.

57. Evidence suggests that cell placement decisions are not revisited on transfer to another correctional facility; they are only reassessed if there is a relevant change of circumstances or new information becomes known. As such, CJ remained a 'normal' cell placement following his transfer to Bathurst Correctional Centre.

58. Dr Sullivan opined that, on the information available to correctional staff, there was nothing to suggest that 'one-out' accommodation was not appropriate.

Can concerned family or friends raise concerns about the welfare of inmates?

59. In the course of the inquest, CJ's wife provided a statement regarding a telephone call she made to Parklea Correctional Centre raising concerns for CJ's welfare with the Governor. There does not appear to be any record of the call at Parklea Correctional Centre, and the position of Governor is now held by a different person.

60. It is unnecessary for me to make a finding about the making of the call. I note the evidence of Dr Sullivan to which I have referred earlier suggests that any change in CJ's management would likely have depended upon his subsequent presentation and any clinical assessment made at that point. That is to say, concerns raised by family and friends may trigger further assessment of an inmate but would not alone result in any change to their management.

61. In any case, the issue as to how family or friends can raise concerns about inmates' mental health was explored in the inquest.

62. The court received information that the Corrective Services NSW public-facing web page includes details about the Justice Health Mental Health Hotline for members of the public who have

concerns about the mental health or safety of their relative or friend in custody. This service is also available to inmates in the custody of Corrective Services NSW, including at Bathurst Correctional Centre. During this inquest, it was identified that the details of the hotline were not readily accessible on the web page.

63. Since the inquest adjourned on 29 March 2023, and as a result of this inquest, Corrective Services NSW has taken steps to place a link to the Justice Health Mental Health Hotline on the front page of its public-facing website. This will ensure that members of the public are more readily able to inform the hotline of any welfare concerns and in turn Corrective Services NSW can take appropriate action.

64. MTC is of the opinion that the Corrective Services NSW public-facing webpage should make it clear that the hotline does not operate in respect of inmates at Parklea Correctional Centre and that contact concerning those inmates needs to be made directly with MTC.

65. The Parklea Correctional Centre telephone is answered 24 hours per day seven days per week. The representative for MTC has submitted that as a result of this inquest considerations are being made to implementing changes to its website to make clear to members of the public who have concerns about the mental health of an inmate, that they should contact MTC rather than Corrective Services NSW or Justice Health, with a direct link to the appropriate telephone number so that the appropriate health service provider or custodial unit manager can be notified.

Were there any circumstances which may have discouraged CJ from seeking mental health assistance? In particular, did the prospect of a change to his 'white card' status (real or perceived) act to discourage CJ from seeking help?

66. In his oral evidence, Wayne Taylor, General Manager Statewide Operations Custodial Corrections Corrective Services NSW, described the colour card system as a visual ready reckoner for corrections staff to ensure inmates are appropriately supervised at all times. Whilst an inmate who was on a green card could not be left alone unsupervised, it was Mr Taylor's evidence that there was no material difference between what possessions a 'one-out' or 'two-out' inmate could be allowed in their cell. He further stated that, when outside the cell, an inmate's liberties or ability to mix with other inmates is unaffected by their card status.

67. In oral evidence, Dr Sullivan was asked whether the prospect of disclosure leading to a risk intervention which could change an inmate's privileges, movements or accommodation was a significant factor affecting the disclosure of mental health issues. Dr Sullivan said:

"My clinical experience is very much that people are very reluctant to disclose self-harm or suicidal ideation. As a psychiatrist people often hint to you but they'll say something as explicit as, "But I don't want to talk about those thoughts because I don't want to lose my cell placement." So they're insinuating that they might have despairing thoughts or thoughts of suicide or self-harm but they won't actually tell you explicitly because they know the consequence of that is to be placed on the risk intervention team, to be moved perhaps to an observation cell. To have objects removed from their cell perhaps to, you know, to move to a different unit so there's a lot of things that people are focused upon which might seem very small to people outside prison but are very big if that's your world".

68. Dr Sullivan went on to observe:

"*The first thing to point out is that you know, prisons are not a place where you're rewarded for disclosing your authentic emotions. They're places where people are - the culture is very much one of keeping a stiff upper lip and maintaining, you know, being staunch in the face of diversity rather than disclosing your vulnerabilities or weaknesses".*

"The other point to make is that from a prisoner's point of view, it's almost indistinguishable if you're placed in a cell for the reasons of punishment, you know, for misbehaviour within the institution or whether you're placed there for self-harm protection. In both cases you lose privileges, you're placed in an austere environment, there's minimal sort of minuscule occupation or stimulation, you have less time out of a cell. So from a prisoner's point of view, expressing suicidal ideation may simply feel to them as if they're being punished afterwards".

Conclusion

69. CJ was in custody on remand for charges relating to the breakdown of his relationship. He had recently suffered the trauma of the loss of his son by suicide. He was extremely emotionally fragile. This scenario highlighted the question of whether concerned family and friends can contact a correctional centre to arrange for extra caution and care of their incarcerated loved one. It became apparent, during this inquest, that the way to do this was not readily available. I hope the changes made as a result of this inquest provide family and friends with the information they need to communicate their concerns to the staff responsible for ensuring the health and safety of their loved ones in custody.

70. I offer my sincere condolences to CJ's family and friends, especially his mother who has suffered greatly since his death.

71. I close this inquest and make the following findings and recommendations:

Findings:

I find that CJ died on 31 December 2020 at Bathurst Correctional Centre, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.

Recommendations:

To the Chief Executive, Justice Health and Forensic Mental Health Network:

1. I recommend that the Justice Health and Forensic Mental Health Network ("Justice Health") make it clear on its public-facing web page, that the Justice Health Mental Health Hotline does not operate in respect of inmates held at Parklea Correctional Centre and that the contact details regarding the mental health of inmates at Parklea Correctional Centre should be provided.

To the Chief Executive Officer, Management & Training Corporation Pty Limited :

1. I recommend that Management & Training Corporation Pty Limited ("MTC") implement changes to its website to make clear that members of the public who have concerns about the mental health of an inmate at Parklea Correctional Centre should contact MTC rather than Corrective Services NSW or the Justice Health and Forensic Mental Health Network. They should provide a direct link to the appropriate number, and it should all be on the front page of its public-facing website.

Magistrate C Forbes
Deputy State Coroner
6 June 2023
Coroners Court of New South Wales, Lidcombe

Note: Findings and paragraph 1 amended 8 June 2023 to correct year of death. Sub-heading preceding paragraph 66 to replace name with pseudonym.