CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of GS
Hearing dates:	3-4 and 6 April 2023
Date of findings:	14 July 2023
Place of findings:	Lidcombe
Findings of:	**Magistrate Kennedy** **Deputy State Coroner**
Catchwords:	CORONIAL LAW – Cause and manner of death, death in custody, mental health, Justice Health waitlists, PAS, complying with patient waitlist timeframes, access to medical practitioners in custody
File number:	2018/281398

Representation:	Ms L Coleman, Counsel Assisting, instructed by T Bird of the Crown Solicitor's Office Mr T Hammond for the Commissioner of Corrective Services NSW, instructed by A McShane of the Department of Communities and Justice, Legal Mr B Bradley for the Justice Health and Forensic Mental Health Network, instructed by K Hinchcliffe of Makinson d'Apice Lawyers Mr R Reitano for Luke Stone, instructed by C Hatzigeorgiou of McNally Jones Staff Lawyers Mr J Raftery for the GEO Group Australia Pty Ltd, instructed by E Lee of Sparke Helmore Lawyers
Representatives (who did not appear at hearing, but subsequently made submissions)	Ms S Idowu and Ms R Dodd of Hall and Wilcox, for St Vincent's Correctional Health Mr S Bailey of Ingenium Legal, for Management and Training Corporation Pty Limited

Findings:	***The identity of the deceased*** GS ***Date of death*** Between 12 and 13 September 2018 ***Place of death*** Goulburn Correctional Centre, Goulburn, New South Wales ***Cause of death*** Hanging ***Manner of death*** Intentionally self-inflicted (in a custodial setting)

Recommendations:	a. **Recommendation one:** That Corrective Services NSW (**CSNSW**) and the Justice Health and Forensic Mental Health Network (**Justice Health**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at the existing correctional centre, and who are in one-out cell placement pending transfer, are to be referred to Justice Health for assessment. b. **Recommendation two**: That Justice Health examine the Patient Administration System (**PAS**) Waiting List Priority Level Protocol and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review. c. **Recommendation three:** That Justice Health consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician. **d. Recommendation four:** That Justice Health consider amending the PAS Waiting List Priority Level Protocol to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the PAS Waiting List Priority Level Protocol) and who are therefore overdue for assessment.

	e. **<u>Recommendation five:</u>** That Justice Health, considers clearly separating the current reporting of overdue patients on the "Overdue PAS report" into discrete individual clinical priority categories to allow proper analysis of the delays experienced particularly by inmates currently delayed on the waitlist, category 3. f. **<u>Recommendation six</u>**: That St Vincent's Correctional Health (**SVCH**) examine the policy titled "St Vincent's Correctional Health: Triage and Priority Waitlist" and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review. g. **<u>Recommendation seven:</u>** That SVCH consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician. h. **<u>Recommendation eight:</u>** That SVCH consider amending the Triage and Priority Waitlist policy to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the Triage and Priority Waitlist policy) and who are therefore overdue for assessment. ***i.*** **<u>Recommendation nine:</u>** That the GEO Group Australia Pty Ltd (**GEO Group**) give consideration to the implementation of a written policy or procedure whereby inmates who are being

	processed for transfer to another correctional centre because of safety concerns at Junee Correctional Centre, and who are in one-out cell placement pending transfer, are to be referred to health staff for assessment.
Non-publication orders	Non-publication orders prohibiting publication of and access to certain evidence pursuant to the *Coroners Act 2009* have been made in this inquest. A copy of these orders can be found on the Registry file.

INTRODUCTION

1. This is an inquest into the death of GS who died at the age of 43 at Goulburn Correctional Centre, in New South Wales. GS had a complex mental health and substance abuse history, and previous attempts at self-harm when he entered custody on 8 February 2018. He was moved between 6 correctional facilities between then and 13 September 2018. GS completed nine Patient Self-Referral forms during the period from February to September 2018. Five of those Patient Self-Referrals contained requests by GS for review by a doctor and / or psychiatrist of his psychiatric medication, together with complaints regarding his mental health and / or ability to sleep.

2. GS was triaged on many occasions to see a General Practitioner (**GP**) or alternatively a psychiatrist. He spent 183 days in custody and did not see a GP or psychiatrist in respect of his medication adjustments that he believed he required. This was, in breach of the triage process in which he should have been seen by a medical practitioner within 14 days to 12 weeks.

3. The focus of this inquest relates to the manner and cause of GS's death, exploring why his mental health was not appropriately attended to, in circumstances where GS followed proper procedure and sought assistance for his mental health.

The nature of an inquest

4. An inquest into GS's death is required to be held and in fact mandatory, because his death occurred while he was in a correctional centre (s. 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009* (**the Act**)).

5. This is important because GS was not at liberty to make arrangements to address his own physical and mental health, and relied instead on the State who was responsible for ensuring that he received reasonable and adequate care and treatment where necessary. The focus of the inquest was to look at contributions to the care of GS, with the major focus being to consider policies and systems in place.

6. I note that it is not the purpose of an inquest to blame or punish anyone for the death. Neither is it any part of the Court's function to make findings about fault or negligence, or to award compensation.

7. The primary function of an inquest is to identify the circumstances of death. At the conclusion of this inquest, I am required by section 81 of the Act to record in writing the fact that a person has died and also to record:

    a. the person's identity;

    b. the date and place of the person's death; and

    c. the manner and cause of death.

8. Another purpose of an inquest is found in section 82 of the Act, and that is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from GS 's death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances. Without limitation, that includes matters of public health and safety, or that a matter be investigated or reviewed by a specified person or body.

Reflection on GS

9. The inquest relates to a significantly troubled period in GS 's life, however GS GS was much more than this to his friends and family, and it is very important before analysing his struggles and mental health to reflect upon the person known and loved by his family and friends.

10. GS was born in 1974. He had two children with his wife, from whom he was separated at the time of his death. He had been in a de facto relationship at the time of his incarceration with his partner since late 2013 or early 2014.

11. In family statements we learned that when GS was well and properly medicated for his depression and anxiety and spending time with those who brought out the best in him he was so kind, recalled as a person who would have "given the shirt off his back" to anyone in need. He was really talented with computers and being loved was important to him. He was trusting and forgiving, and sadly that led to trust being placed in others who abused his trust. He followed

some into drug use and became severely addicted. If unmedicated, his family recall he could demonstrate psychotic symptoms, especially when withdrawing from drug use, but this was not who he really was to those who loved him.

12. He is remembered for being unlike other men, being boyish, with a beautiful smile. He was encouraging and proud of his family and tried his best to support them. He struggled with chronic pain, migraines, ADHD and mental health, all the while trying to live by his chosen religious beliefs and values.

13. He was inquisitive, enjoyed educating himself, and he loved music. He wanted to help others and set up a free online meeting for people struggling with narcotic addictions. This made it easier for those with difficulties and issues to get to meetings.

14. He is remembered by his children for his love for music and is fondly remembered for playing his music loudly. He would share his enjoyment of Star Wars with his children, take them for walks along the river and even surprised them with a pet.

15. His friend travelled a long distance to attend the inquest and make a very moving statement. He recalled the person who helped free him from his own addiction, who cared when others didn't and who continued to support him even when GS GS himself was no longer managing as well. He described a giving and caring human being, who just had, for the time, lost his own way.

Outline of the background to GS

16. GS died on 12 or 13 September 2018 at the age of 43. Counsel Assisting presented a non-controversial factual background which I now relate below. Given the concerns in this matter relate to GS requesting mental health treatment and failing to receive it following his requests, it is important to go into the full details of the factual background. Some of the background material is distressing, but necessary given GS 's complex issues.

17. GS had a history of significant mental health and substance abuse issues. He had been diagnosed with borderline personality disorder, Attention Deficit Hyperactivity Disorder, substance use disorder, persistent depressive disorder, gambling disorder and previous drug-induced psychosis. He was prescribed with antipsychotic and antidepressant medication in the period prior to his incarceration,

including daily Seroquel (Quetiapine) and Zoloft (Sertraline). GS reported that he was sexually abused for approximately six months at the age of 11 or 12, and that he commenced substantial drug use at that time.

18. He had ongoing problems with methyl-amphetamine use. GS received drug and alcohol treatment at Cyrenian Centre in Stanmore for over eight months in 1997. In March 2013, he was admitted overnight to Banks House (an acute adult mental health unit at Bankstown Hospital) with suicidal thoughts, and was subsequently admitted to Concord Hospital. In late 2013 he attended The Hills Hospital for treatment of substance abuse issues.

19. GS was taken into custody on 8 June 2016 bail refused on shoplifting and related charges. A nursing entry in GS 's progress and clinical notes on that date records that he "stated on his lodgement that he was going to kill himself". He attempted to cut his wrist while in the police cells. A "D&A and MH Summary" prepared for Corrective Services New South Wales (**CSNSW**) on 13 June 2016 records that GS had tried to hurt himself and to end his life; that his last attempt was 3 days ago; and that he "would have tried 4/7 ago--but nothing to do it with". GS was assessed by the Risk Intervention Team (**RIT**) at Metropolitan Remand and Reception Centre (**MRRC**) on 14 June 2016, which recommended that GS be referred to a Mental Health Nurse, and placed two-out in his cell until cleared by primary health. GS was released from custody on 15 June 2016 on appeals bail.

20. From 31 August 2016 to 20 September 2016, GS was admitted to the Sydney Clinic for addiction and mental health issues. He was then admitted to The Hills Clinic from 28 September 2016 to 18 October 2016 with psychotic symptoms. It appears that he had also been admitted to The Hills Clinic in January 2016.

21. GS entered custody on 8 February 2018 on charges of common assault, contravene prohibition in AVO and damage property by fire after allegedly assaulting his partner and burning down their house on 5 February 2018. He was taken to Prince of Wales Hospital on 8 February 2018 for medical assessment and reviewed by Dr Kylie Cheng, who concluded that GS did not meet the criteria to be scheduled as a mentally disordered patient and released GS to police custody. Upon his return to custody, GS told officers that he "just wants to

die", that he "wished he could do it as his life is fucked" and "wished he had the guts to kill himself".

22. GS was transferred between a number of different correctional centres between February and July 2018, as follows:

    a. on 14 February 2018 he was transferred from police cells to MRRC;

    b. on 2 March 2018 he was transferred to Parklea Correctional Centre (**Parklea CC**);

    c. on 29 March 2018 he was transferred to Junee Correctional Centre (**Junee CC**);

    d. on 25 and 26 April 2018 he was transferred to MRRC via Bathurst Correctional Centre for assessment for a Court-ordered psychiatric report;

    e. on 7 May 2018 he was transferred from MRRC to Kariong Correctional Centre (**Kariong CC**);

    f. on 29 May 2018 he was transferred back to Parklea CC; and

    g. on 2 July 2018 he was transferred to Goulburn Correctional Centre (**Goulburn CC**) where he remained until his death.

23. Parklea CC and Junee CC are privately operated. In 2018, Parklea CC was operated by the GEO Group Australia Pty Ltd (**GEO Group**) and healthcare services at that centre were provided by the Justice Health and Forensic Mental Health Network (**Justice Health**). Parklea CC is now operated by Management & Training Corporation Pty Limited (**MTC**), and healthcare services are provided by St Vincent's Health Network (via St Vincent's Correctional Health). Junee CC was and remains operated by the GEO Group, with healthcare services provided by the same entity. All other correctional centres of which GS was an inmate in 2018 were and remain operated by CSNSW, with healthcare services provided by Justice Health.

24. GS 's earliest possible release date was 29 August 2018. He had a Court appearance on 11 September 2018, and his next Court appearance was listed for 5 October 2018 at Penrith District Court.

25. On 13 September 2018 at approximately 8.28am, a correctional officer opened the door to GS 's cell and found GS hanging from the bars of the cell window. Bed linen had been used to create a ligature around his neck. GS was pronounced deceased at 8.30am by a Justice Health Nursing Unit Manager.

26. A handwritten note from GS to his partner dated 12 September 2018 was located inside GS 's cell on 13 September 2018. Among other things, GS GS stated in his note that "there is no hope of this stopping except to kill myself" and set out his "will and funeral arrangements". Also located in GS 's cell was an inmate application form signed by GS and dated 12 September 2018, in which GS was seeking to have non-association orders placed on two named individuals who had been threatening him and also expressed his wish to move yards or prisons.

27. Following GS 's death, other inmates at Goulburn CC reported that he "just seemed to be very upset a lot", that he was bullied and picked on by other inmates, that he "seemed [to be] a loner", and that he was often observed to be crying in the yard or in his cell, including as recently as the day before his death.

28. In her autopsy report dated 26 July 2019, forensic pathologist Dr Rebecca Irvine recommended that the direct cause of death be recorded as "hanging". She eliminated the involvement of any third party or any further cause.

FACTUAL BACKGROUND

Consideration of the care and treatment of GS from February to September 2018

HPNFs, mandatory notifications and RIT assessments

29. GS 's time in custody commenced in a concerning fashion. On 11 February 2018, a Mandatory Notification for Inmates at Risk of Suicide or Self-Harm was made after his partner told police that GS had attempted suicide in custody twice in the past. GS 's cellmate also reported that GS had been

attempting to choke himself in the cells. He had just arrived and was attempting self-harm.

30. GS was placed on a Risk Intervention Team (**RIT**) and scheduled for review by the Risk Assessment Intervention Team.

31. On 14 February 2018, GS was transferred to MRRC. He was placed on a RIT and put in a camera assessment cell until he could be reviewed. On 14 February 2018, records note that GS had previously tried to self-harm but that he had not attempted to end his life. However, the RSA Clinical Summary dated 13 June 2016 identifies that GS had previously attempted to commit suicide; the NSW Police Force Custody Management Record dated 8 February 2018 records GS expressing suicidal intent on that date and provides an affirmative answer to the question "Have you ever tried to kill yourself"; an Inmate Profile Document dated 14 February 2018 identifies an "active" alert for self-harm in respect of the June 2016 incident; and a CSNSW Intake Screening Questionnaire dated 14 February 2018 states "previous suicide attempts in custody, attempting to choke himself in cell".

32. On 16 February 2018, GS was interviewed by a team consisting of an Assistant Superintendent, Services and Programs Officer (**SAPO**) and a registered nurse from Justice Health. The RIT case notes of that record that GS "admitted he may have said he would use his razor to slit his throat at court" but that he is "not going to do it", and that "he only actually self harm / suicide once in the past, in June 2016 by using a metal piece to cut his arm". The progress clinical notes record that GS said "if …..wanted to kill myself, I would have did it last 18 months … I wanna live through this … Got a lot of things to look forward to in life". The RIT case notes also record GS saying "I have got lots of mental health issues but [? not] given my medication now".

33. GS was assessed as "not at risk of self-harm / suicide". His RIT was terminated, and he was recommended for two-out cell placement until 1 March 2018 then normal cell placement. The RIT case notes also state "Hold in Darcy till cleared by mental health team". A Health Problem Notification Form (**HPNF**) dated 16 February 2018 advised officers to monitor GS for "mental health issues".

34. As per usual process, a mental health assessment of GS was undertaken on 18 February 2018 by a registered nurse from Justice Health. That document records that GS had a history of depression and anxiety and was generally on Seroquel/Zoloft; that he had past admissions to Concord Hospital, Banks House and "multiple rehabs. placement"; that he had a history of suicide attempt; and that at present, "sleep – poor … Limited supports". GS was described as being tearful and flat, with a reported mood of "3-4/10". The document also notes "slashed wrist w small blade" and "auditory hallucinations – whilst on drugs". Under the heading "provisional diagnoses", The nurse recorded only "nil psychoses". The "risk assessment" portion of the Mental Health Assessment had not been filled out at all, nor had the section entitled "Formulation / Overall clinical impression". GS GS's initial management plan is recorded as "~~Hold~~ cleared from Darcy … two-out til 1/3/18". There was no answer provided to the question "Has the Plan been discussed with a Consultant Psychiatrist/Senior Clinician".

35. This was the only Mental Health Assessment carried out in respect of GS during his entire time in custody.

36. Also on 18 February 2018, GS was placed on Special Management Area Placement, known as "SMAP", for a period of 6 months after being threatened by another inmate at MRRC. He was to be reviewed on 17 August 2018. In essence, he required protection.

37. GS was again placed on a Mandatory Notification Form (**MNF**) on 25 February 2018. After a visit, he was yelling and crying, very upset. An incident report records that GS stated that he "doesn't want to go back into his cell with his cell mate or he will punch him" and that "the next chance he has he will end his life … if we put him back into his cell in pod 8 he will kill and cell mate [sic] because he has nothing more to live for". An Immediate Support Plan was implemented; GS was escorted to a safe cell by the Immediate Action Team and placed on 24 hour observation. He had been in custody for 17 days, during which time he had not been given his usual medication.

38. On 27 February 2018, a second RIT assessment of GS was conducted at MRRC and that assessment recorded that GS was "teary, saying it would

not have happened if he had his medication earlier" and that he said "I need my medication, I've asked for 20 days for my medication – my Zoloft and my Seroquel". To similar effect, the progress / clinical notes prepared by the nurse record that GS GS was "upset that he has not yet had medication → Quetiapine / Sertraline". Case notes state that he was "histrionic, unsettled & mentally unstable, crying and emotional", that he "thinks he is withdrawing 'misses' the drugs" but that he denied immediate current self-harm.

39. GS was diagnosed with "situational distress" or "situational anxiety". He was assessed as a "low immediate risk of suicide / DSH" (that is, deliberate self-harm). GS 's MNF was terminated on that date and he was recommended for group cell placement for a period of 6 weeks (until 10 April 2018) then normal cell placement. The Justice Health nurse from the RIT team on 27 February 2018 says that she and the RIT formed the view that group cell placement was indicated as a protective factor, given that GS had not yet been commenced on his medication and given that he had had two RIT assessments in a short period of time.

40. There is no criticism of those tending to GS however it does seem incongruous that even after two RITs and concerns of suicide he continued to remain unmedicated, even after expressing his own observations that this was contributing to the situation.

41. None of the contemporaneous progress notes or case notes from this review make any reference to GS 's history of self-harm or attempted suicide or to his mental health history more broadly, including past admissions to mental health units whilst in the community.

42. GS was then transferred from MRRC to Parklea CC on 2 March 2018 and subsequently to Junee CC on 29 March 2018. The Parklea CC Reception Committee Screen dated 9 March 2018 contains a referral to "Psychology – MH counselling". Similarly, the Junee Reception Committee form dated 29 March 2018 identified that GS is on SMAP status, and the Junee CC Receiving Screening form of 29 March 2018 refers GS to *inter alia* "MH". It appears

that GS remained two-out at both Junee CC and Parklea CC until 10 April 2018, as had been recommended by the RIT on 27 February 2018.

43. GS 's case file includes a "Reception and accommodation checklist", in which most fields have not been filled out. The form is undated, and does not identify the correctional centre in question. While the form identifies that GS requires protection (presumably on the basis of his SMAP status), the box next to "self-harm history" has been ticked "No" and the form recommends GS for normal cell placement.

44. GS was transferred to Kariong CC on 7 May 2018. A Reception and accommodation checklist dated 7 May 2018 identified that GS had a history of self-harm and protection. A HPNF dated 8 May 2018 prepared by a registered nurse records "Hx Mental Health. Depression; Hx of Self Harm; Monitor: Fluctuations in mood". Notwithstanding those matters, GS was recommended by the nurse for normal cell placement. A progress note prepared by the same nurse on that date records that "Pt denied any concerns. Pt reports [nil] concerns with cell placement. Mx given as charted".

45. The nurse's HPNF of 8 May 2018 at Kariong CC was the last HPNF prepared in respect of GS . Her recommendation that GS was suitable for normal cell placement (that is, either one-out or shared) assumes some significance in relation to the decision of then Senior Correctional Officer (**SCO**) Luke Stone on 12 September 2018 to transfer GS from a two-out cell to a one-out cell at Goulburn CC pending his transfer to another correctional centre.

46. Terry Murrell was formerly the General Manager of State-wide Operations within the Custodial Services Branch of CSNSW. Mr Murrell says in his statement that inmates are assessed by Justice Health staff on reception, or at any time as required, and that following completion of that assessment Justice Health provides CSNSW with a HPNF. Where an inmate is transferred to a new correctional centre, Justice Health staff will undertake a Reception Screening Assessment and generate a new HPNF if required. No Reception Screening Assessment undertaken by Justice Health staff upon GS 's arrival at Goulburn CC on 2 July 2018 was in evidence.

Patient Self-Referrals

47. As noted above, GS completed nine Patient Self-Referral forms during the period from February to September 2018. Five of those Patient Self-Referrals contained requests by GS for review by a doctor and / or psychiatrist of his psychiatric medication, together with complaints regarding his mental health and / or ability to sleep.

48. The Patient Self-Referral forms completed by GS in 2018 are as follows:

    a. on 23 February 2018, GS requested to see a doctor for psychiatric medication, which he had been asking to receive since his arrest on 8 February 2018. The form was received on 27 February 2018 and notes "ROI on JHeHS for R/V". This means that a waitlist entry has been generated to ensure that the medical records provided from GS 's time in the community and loaded into the system were reviewed;

    b. on 12 March 2018, GS asked to see a nurse noting he was "not a risk to myself since being on my psych meds and having settled in". The form was received on 14 March 2018 by an RN, and notes "…Primary Health appointment booked for 27/3/18";

    c. on 29 April 2018, GS requested to see a psychiatrist to "review medications I receive for depression [and] anxiety. I am having trouble with feeling agitated and depressed and having some trouble sleeping, an increase in Zoloft [and] Seroquel would help". He was noted to already be on the psychiatrist referral list.

    d. on 30 April 2018, GS again asked to talk to a nurse about being reassessed as "my mental health is stable". The form notes "on PHN + ? W/L";

    e. also on 30 April 2018, GS completed a second Patient Self-Referral form in which he noted that he had "had migraines and

headaches since age 7" and that he needed to see a doctor so he could at least get some paracetamol or ibuprofen;

f. on 9 May 2018, GS stated that "I need psych medication review – still agitated and difficulty sleeping" and also sought pain management for migraines and treatment for fractures in his feet. The form has the following notation: "on list";

g. on 18 June 2018, GS requested to talk to a nurse for assessment for pre-release suboxone / methadone maintenance so that "I can be stable on release". GS noted that he was eligible for release on 29 August 2018. The form notes "on D&A list";

h. on 20 June 2018, GS wrote that "I need to see psychiatrist to get antidepressant and mood stabilizers [sic] reviewed. I am having great difficulty sleeping and have been depressed. Likely need increase of Seroquel and Zoloft. I am only on low – starting doses". The form notes "on GP list"; and

i. on 4 July 2018, GS wrote that "I need to see a doctor/psychiatrist to review psych meds as I can't sleep and am agitated and want to be stabilised prior to release on 29/8/18". He also wished to "see about methadone or suboxone maintenance prior to release if possible to reduce risk of relapse & reoffending". The form was received on 5 July 2018 by an Enrolled Nurse, who placed GS "on PHN WL + MH WL to be r/v. Pt on current WL for D+A".

49. The Justice Health policy titled "Patient Self Referral for Health Assessment in the Adult Ambulatory Care Setting (Non urgent Issues Only)" states that Patient Self-Referral forms are "designed to provide patients with a means of alerting JH&FMHN staff to non-urgent medical matters or to request an appointment with specific health staff members". It identifies that Registered or Enrolled Nurses are responsible for triaging and assessing patients and that the Patient Administration System (**PAS**) waiting list clinical priorities definition should be used as a guide when determining the clinical priority.

50. To that end, the Justice Health policy titled "PAS waiting list priority level protocol" provides the following description of the various clinical priority categories:

    a. category 1 (urgent) is for patients whose health condition is deteriorating and requires attention within one to three days;

    b. category 2 (semi-urgent) is for patients where lack of immediate intervention may result in an adverse outcome and requires attention within three to 14 days;

    c. category 3 (non-urgent) is for patients who are stable but will require attention within 14 days to three months;

    d. category 4 (routine) is for patients who are stable but require intervention within 12 months; and

    e. category 5 (follow up) is for patients requiring follow up after their initial assessment within a designated timeframe that is determined by the treating clinician.

51. Regional Nurse Manager Gary Clark provided a statement dated 25 March 2020. Mr Clark was not involved in the treatment of GS, and he based his statement upon his review of the clinical record. Mr Clark says in his statement that GS was added to the Primary Health Nurse waitlist on 26 February 2018 as a priority 5. According to Mr Clark, on 5 April 2018 GS was placed on the waitlist for the GP Primary Health Clinic as a priority 4 (routine) though it appears from the waitlist report itself that GS was allocated a priority 3 on that occasion; on 5 July 2018 GS was again placed on the Primary Health Nurse waitlist as a priority 3 (non-urgent); and on 26 July 2018 he was placed on the Mental Health Nurse waitlist as a priority 4 (routine).

52. GS attended several appointments with the Primary Health Nurse at Kariong CC in May 2018, and on 30 August 2018 he attended a Primary Health Nurse appointment off the Primary Health waitlist at Goulburn CC with an RN. The progress / clinical notes of that latter consultation record that GS was "worried about meds and no longer helping. Requesting increase". GS was

placed on the Mental Health waitlist (albeit that he had apparently already been placed on that waitlist on 26 July 2018) and he was also placed on the GP waitlist for regular analgesia.

53. GS did not see a GP at any time during his incarceration over approximately 183 days from February to September 2018. He had appointments with a GP scheduled for 1 June, 6 June and 12 June; however, Mr Clark says that each appointment was cancelled by the GP (due to the GP cancelling the clinics). GS GS also had an appointment with a GP scheduled for 1 August 2018, which was cancelled by CSNSW because Goulburn CC had an unscheduled lockdown on that date. In that respect, as of 2020 Goulburn CC's operational model was amended to allow booked medical services such as dental, mental health and GP clinics to remain operational during lockdowns.

54. On 27 April 2018, GS was interviewed at MRRC by a consultant psychiatrist within Justice Health, Dr Gerald Chew, for the purpose of a Court-ordered psychiatric report. However, it appears that notwithstanding GS 's repeated requests for his psychiatric medication to be reviewed, no such review was conducted at any stage of his incarceration by a psychiatrist (or GP) following the initial prescriptions for Quetiapine and Sertraline. GS 's medication chart indicates that he was administered Quetiapine and Sertraline daily from 1 March to 12 September 2018. Sertraline (or Zoloft) is an antidepressant administered in the mornings, and Quetiapine (or Seroquel) is an antipsychotic administered nightly. Those medications were prescribed by a psychiatrist on 1 March 2018 without a personal consultation.

55. Mr Clark says that the mental health waiting list times vary between facilities "due to not all facilities having a Mental Health Nurse". As at 2018 and currently, each of MRRC, Parklea CC and Goulburn CC had and continue to have one or more mental health nurses on site.

56. Kariong CC did not have an on-site mental health nurse in 2018, and patients requiring review by a mental health nurse or psychiatrist had to be transferred to another correctional centre. Currently patients can be reviewed by a mental health nurse at Kariong CC via telehealth.

57. In that respect, GS did not have any consultations with a Mental Health Nurse whilst he was in custody from February to September 2018 other than his review at MRRC on 18 February 2018. While GS had a telehealth consult scheduled with a mental health nurse on 21 May 2018 at Kariong CC, that appointment did not proceed due to technical issues with telehealth, which was a frequent issue at the time.

58. Mr Clark says that Justice Health is utilising a telehealth system to enable better patient access to mental health clinicians and is working to increase the availability of telehealth services. The telehealth service commenced in September 2018, and allows for review via telephone or video by a GP, mental health nurse or psychiatrist when it is not possible for them to occur in person. Telehealth services are available at certain correctional centres, though not at any of the centres of which GS was an inmate, with the exception of Kariong CC.

GS *'s consultation with psychology staff on 10 September 2018*

59. At approximately 3.25pm on 10 September 2018, GS was reviewed by provisional psychologist Sarah Genthner under the supervision of senior psychologist Patrick McMaster at Goulburn CC. The purpose of that review was to screen GS 's current service needs. The notes of the consultation record that GS was "seen from subacute mental health service line". It appears that he had psychology referrals dated 22 February, 6 March, 9 March and 11 April 2018.

60. Mr McMaster says in his statement that the GS was seen by psychologists at Parklea CC on 7 March 2018 and 12 March 2018, at Junee CC on 10 April 2018 and 16 April 2018, and again at Parklea CC on 15 June 2018. Mr McMaster says those prior sessions "provided relevant CBT coping skill strategies and counselling" and that on each occasion GS "denied any suicide or self injuries ideation".

61. According to Mr McMaster, at Goulburn CC all psychologist triaging and interventions are performed twice daily: in the mornings at 11.30am and in the afternoons at 2.30pm. Mr McMaster says that following GS 's arrival at Goulburn CC on 2 July 2018, psychology staff attempted (but were unable) to see

GS on 31 July 2018, 3 August 2018, 24 August 2018, 4 September 2018 and 5 September 2018, mostly due to lockdowns.

62. In the result, GS 's consultation on 10 September 2018 was his first (and only) session with psychology staff since his transfer to Goulburn CC on 2 July 2018.

63. Mr McMaster provided that during his consultation with Ms Genthner on 10 September 2018, GS was alert and oriented to time, place, person and purpose and that GS "advised that he had no current thoughts of suicide or self-harm and rated his mood as a 7 out of 10". GS is said to have declined a need for one to one service; however, Mr McMaster says that GS would probably still benefit from participation in the RUSH (Real Understanding of Self Help) program because it is a dialectic behaviour therapy specifically designed for suicide, self-harm and self-injurious behaviour in a prison setting. GS agreed to participate in that program.

64. At the review, GS again asked for his medication to be reviewed but he was advised that the psychologists could not assist with medications and further that he would have to put in a referral to the Clinic. Ms Genthner recalls that GS 's mental state presentation during that interview was "unremarkable".

65. Mr McMaster could not recall whether he reviewed GS 's Justice Health file at the time, where GS 's Patient Self-Referral forms were maintained in hard copy at that time. Justice Health policy permits CSNSW's psychologists to access Justice Health file records with the client's consent, or when the inmate is under the care of the psychologist. Mr McMaster says that on 12 August 2021, CSNSW psychologists were granted direct access to Justice Health's electronic file system to enhance access to client files.

The events of 12 September 2018

GS *'s relocation to a one-out cell*

66. On 12 September 2018 prior to 11am, SCO Stone interviewed GS in the rear office of Unit 2 at Goulburn CC. GS advised SCO Stone that he had

concerns for his safety in the yellow yard, and that two other inmates had told him he needed to be out of the yard by 11am that day. According to SCO Stone, GS GS was "teary and upset".

67. SCO Stone provided GS with an "inmate application form" for the purpose of recording his safety concerns and told GS that he would need to lock him in a single cell until he could be moved. SCO Stone then escorted GS back to his cell and advised him to pack up so that he could be moved. SCO Stone sent an email to officers informing them of the situation, and asking that a new facility be found for GS, as the placement options had been exhausted. At 12.28pm, SCO Stone escorted GS to cell 5 and secured him in his cell. SCO Stone asked GS if he was alright to be alone, and he was reassured by GS GS. He also spoke to SCO Michael Maddock about placing GS one-out until he was moved from Goulburn CC.

68. A fellow inmate at Goulburn CC at the time says in his statement that [redacted] GS [redacted] GS had paid for some drugs that were being sold by other inmates in the yellow yard, but that he had not been given those drugs. When GS raised that issue with other inmates "he was told he would have to leave the yard or he would be stabbed". The inmate said that on 11 September 2018 after midday, he spoke with GS in the yellow yard and GS said to him "I don't want to be here anymore, I'm going to end it, I don't want to be here anymore I'd rather be dead than stay in Gaol". The other inmate did not think GS was serious because "[redacted] we do not believe in suicide", and he therefore did not tell anyone about this conversation until after GS 's death.

69. In his second statement SCO Stone says that, given that he did not know which inmates had threatened GS, he believed the best option was to place GS GS one-out in a cell alone. According to SCO Stone, GS "wasn't aware of the last names of the inmates who had threatened him, only their first names". However, in the inmate application form completed by GS on 12 September 2018, GS identified two individuals that had each threatened him and that he wanted non-association orders placed on each of those individuals. There were already active non-association orders in respect of six individuals at the time. There

is no suggestion that GS 's then current cellmate posed any threat to GS GS 's safety; indeed, provisional psychologist Ms Genthner who interviewed GS GS on 10 September 2018 observed that GS was then placed two-out in a cell with a cellmate that he got along with.

70. Shortly prior to SCO Stone escorting GS back to his cell, GS placed a telephone call to his sister in the company of a SAPO, Nicolle McClelland. GS GS told his sister that he needed to organise an address for his bail and, in response, his sister told him that she could not assist him with that. GS then slammed the receiver down and said to the SAPO "well that's it, I got another fucking nine months … my sister was my only option". GS was then escorted to an office where Senior Assistant Superintendent (**SAS**) John McInnes and Classification Co-Ordinator Cindy McCowan were waiting, and GS there repeated "I got nine more months".

71. SCO Stone was not informed of the full nature of this telephone call or GS 's reaction following that call. That is relevant in circumstances where GS was placed one-out in a cell with hanging points shortly after receiving news that evidently caused him distress or disappointment and that caused him to believe that he would be serving out his term for an additional nine months, and this occurred just after he has disclosed threats to his person. To that end, the handwritten note located in GS 's cell on 13 September 2018 (dated 12 September 2018) addressed to his partner states that "I just can't go through this, especially now I know it is at least 7 months again … now the hope of release is gone … I can't live another year in here". The note discloses that the bail difficulty that he faced was an upsetting factor for him.

72. Ms McClelland's role at Goulburn CC as a SAPO was to assist with inmates' welfare and to arrange programs that the inmates may require, such as drug and alcohol counselling. 12 September 2018 was the first time that SAPO, Ms McClelland had any interaction with GS . Ms McClelland says that shortly before GS telephoned his partner, GS informed Ms McClelland that he needed to get out of the yellow yard as he had been advised to get out of the yard by 11am that day and feared he would be bashed. On that basis, following GS 's telephone call with his sister on 12 September 2018, Ms McClelland

told GS that "we needed to focus on moving him for his safety". At that time, Ms McClelland was aware that GS was being interviewed by Classification Officers but did not know that he was to be relocated to another correctional centre. She was also aware that GS was to be moved from his current cell placement, but did not know whether he was to be placed one-out or two-out.

73. The Review of Classification prepared by Ms McCowan (and seemingly also by SAS McInnes) on 12 September 2018 identifies that GS has a history of self-harm or suicide, and states in the "comment" field: "6 Months ago nil current thoughts". On completion of the review, it was recommended that GS revert to a "B Unsentenced Remand Bed" placement. Ms McCowan recalls that GS "appeared teary and upset" when he attended for that review.

GS *'s medication*

74. At 2.06pm on 12 September 2018, SCO Robert Geurts was providing meals to inmates who were locked in when GS asked to speak with him. GS asked SCO Geurts about his medication, informing him that he had missed his medication after being removed from the yard. SCO Geurts said that he would make sure he received his tablets during the regular pill drop at about 6.30 pm. According to SCO Geurts, GS did not seem overly depressed and gave no indication that he would harm himself. SCO Geurts did not have any background information in relation to GS.

75. GS then contacted SCO Maddock again inquiring about his medication. SCO Geurts told SCO Maddock that he had already spoken to GS about that issue. SCO Geurts then contacted the clinic and informed the nurse that GS GS needed to have his medication delivered during the night drop off.

76. At approximately 6.34pm on 12 September 2018, a Justice Health nurse attended the door of cell 5 and pushed GS 's medication through the cell door observation hole. That is the last known person to have approached GS 's cell and have any interactions with him. There was no reported conversation at that time.

Steps taken or considered by CSNSW since GS 's death

77. In his statement, Mr Murrell says that CSNSW's Custodial Corrections Branch has undertaken a multi-stage project aimed at reducing the number of ligature points in NSW correctional centres. Window grills have now been fitted at Goulburn CC to cover exposed window bars, while CSI high security beds have been installed with a view to eliminating obvious ligature points.

78. Mr Murrell also says that following previous coronial recommendations, representatives from CSNSW and Justice Health have formed a joint working group aimed at (among other things) improving communication, collaboration and information-sharing between CSNSW and Justice Health. The joint working group schedules quarterly meetings to discuss joint coronial recommendations.

79. A CSNSW Investigation Report prepared by Senior Investigations Officer Graham Kemp in March 2019 identifies that, given the threat of physical violence and the removal and isolation from others which occurs to an inmate in such circumstances pending transfer to another centre, it may be prudent for the introduction of policy which triggers an immediate assessment by Justice Health prior to securing said inmate in a cell.

80. As to that suggestion, Mr Murrell says that inmates are assessed by Justice Health on reception, or as required, and once an assessment is complete Justice Health provides CSNSW with a HPNF. Mr Murrell could not confirm whether any proposed recommendation for a policy inclusion regarding Justice Health assessment following a threat of physical violence and isolation from others would be supported by CSNSW. He also said that there have been no formal policy changes to the operation of access to Justice Health by inmates, including access to those services on an informal basis.

Transfers between correctional centres

81. The evidence was not clear as to why GS was being moved around facilities.

82. On 23 April 2018, GS wrote a letter to his children in which he stated:

> "I don't get to choose where I go, they can move us around anytime – a few weeks ago I got woken up at 4am and told I'm on 'escort', and I came down

here from Parklea … It's better here, nicer conditions, but so far away for visits and phone calls cost more. And it's still really boring, but I'd rather really boring than really scary or hard, which it has been sometimes …
I have made some friends here, there are some good people and a heap of people who aren't very nice sometimes."

83. It does appear on a number of occasions that GS was having difficulty with other inmates, and had received threats. On 16 May 2018, shortly after his transfer from Junee CC to Kariong CC on 7 May, GS told CSNSW officers that he "need[ed] to get out of … this Gaol", and that "they" (being two named individuals) think I'm a dog, I'm not a dog". GS said that one of those individuals "was trying to get cigarettes in they think that I dogged him". GS advised officers that he feared for his safety, and completed an inmate application form in which he asked to be kept safe from each of the two named individuals "and people they are connected to". On 17 May 2018, non-association orders were placed on the two named individuals and on 29 May 2018, GS was transferred from Kariong CC to Parklea CC. The transfer form records the reason for transfer as "not suitable for KCC".

84. GS then sought a Protective Custody review at Parklea CC. On 16 June 2018, he informed CSNSW officers that he feared for his safety and that he had been verbally threatened by three named inmates "due to issues at previous gaol". GS said that if he was not moved to alternative housing he will "get got".

85. The CSNSW Placement / Threat Assessment carried out on that date rated the likelihood of a threat occurring as "High (probably occur)" and the overall threat rating was also "High – Protective custody recommended". On 16 June 2018, non-association orders were placed on three individuals for a period of 12 months. A classification assessment was subsequently carried out on 19 June 2018, and GS was recommended for placement at Goulburn CC. it was recorded that there were active non-association orders in place at Parklea CC, MRRC and Kariong CC and that GS was not to be placed at Kariong CC. In accordance with his recommendation, GS was transferred to Goulburn CC on 2 July 2018. The transfer form in respect of GS's move from Parklea CC to Goulburn CC on 2 July 2018 records the reason for transfer as "CD 25/06/2018".

86. It therefore appears from the brief of evidence that GS was likely transferred out of MRRC on 2 March, Kariong CC on 29 May and Parklea CC on 2 July as a result of the threats which GS reported that he had received from other inmates at each of those facilities. However, the reason for GS's transfer from Parklea CC to Junee CC (on 29 March) and from Junee CC to Kariong CC (on 7 May) is not clear. The transfer forms in respect of GS's movements from MRRC to Parklea CC (on 2 March), from Parklea CC to Junee CC (on 29 March) and from Junee CC to Kariong CC simply record the reason for transfer as "remand bed placement".

EXPERT REPORT OF ASSOCIATE PROFESSOR SULLIVAN

87. Consultant forensic psychiatrist and Associate Professor Dr Danny Sullivan has provided an expert report in this matter dated 3 March 2023. Dr Sullivan is a Fellow of the Royal Australian and NZ College of Psychiatrists, and was formerly the Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health. He has clinical experience in community, prison and forensic hospital settings, as well as management and governance experience. Dr Sullivan observed that in adult life, GS clearly met criteria for a severe substance use disorder and the material suggested likely recurrent depressive disorder. Dr Sullivan also observed that the material disclosed that GS had significant gambling problems, and that he reported a history of migraines, though Dr Sullivan could make no formal diagnosis in respect of either on the material available to him. Dr Sullivan noted that GS's period in custody in 2018 was his second period of incarceration, that he had shown evidence of significant distress upon each episode of imprisonment with intermittent threats of self-harm and suicidal ideation, and that it was apparent that GS had interpersonal issues with other prisoners.

88. Dr Sullivan also noted that at the time of his death, GS was subject to several significant stressors, including an inability to obtain bail, threats from other prisoners, an incapacity to obtain illicit drugs and a "longstanding inability to access psychiatric and/or medical review to discuss his psychiatric medications and their dosages, and to address headaches".

Failure to provide appropriate mental health care and treatment

89. Dr Sullivan's opinion is that GS did not receive appropriate mental health monitoring, care and treatment during his imprisonment in 2018. Dr Sullivan noted that GS 's history placed him in a category of prisoners with a higher likelihood of meeting mental health diagnoses and thus warranting medical review. His history of self-harm and suicidal ideation placed him at an increased lifetime risk of death by suicide.

90. Dr Sullivan's view is that the initial or comprehensive review of GS based on his mental health history should be conducted by a psychiatrist. Psychiatrists have specific skills and training in the holistic assessment of the patient, and specific expertise in the adjustment and alteration of medications when indicated.

91. Dr Sullivan expressed his opinion that GS should have been assessed by a GP given his reported, documented history of migraine and complaints that he needed treatment for this.

92. Dr Sullivan could find no evidence that GS was reviewed by a medical practitioner, whether a GP or psychiatrist, at any stage of his incarceration.

93. The psychiatrists who continued medication on drug charts did not have the benefit of a face to face assessment of GS , and from that perspective it is difficult to justify adjustments in medication or dosage without having assessed the patient. Dr Sullivan said that while continuing medication without a face to face review may be practicable in the short-term, it should not be a sustained policy.

94. Dr Sullivan has no issue with GS 's placement in the non-urgent clinical priority category in the GP and mental health waitlist. However, Dr Sullivan's opinion is that "cumulatively, continued requests for assistance met with no effective response" and that "[o]ver time, the continued failure of the correctional health care system to facilitate a medical and/or psychiatric review should have increased the urgency of need of review".

95. As regards GS 's medication, Dr Sullivan said that Sertraline 100mg is a low-moderate dose and that given his recurrent complaints, distress and reported

symptoms, it is likely that this dose would have been increased to 150 or 200mg daily if he had been reviewed by a psychiatrist; alternatively, another medication might have been trialled. GS 's other medication, Quetiapine 100mg, was a low dose typically prescribed off label for nocturnal sedation and anxiety. Dr Sullivan observed that while GS reported benefit from Quetiapine for distress, this is not being used for an appropriate indication and many psychiatrists working in prison settings would elect to cease it.

96. Dr Sullivan could not determine that the absence of any medical review actually contributed to GS 's death. However, his opinion is that there is a reasonable possibility that GS 's mental state would have been clarified and a management plan put in place had he been reviewed by the GP, and particularly if seen by a psychiatrist or registrar. That opinion is based upon the "clear evidence" that GS considered that his medication regimen was not meeting his needs, and his repeated requests for its review. Ongoing action to improve his mental state would almost certainly have required alteration of medication.

GS 's relocation on 12 September 2018

97. In relation to the decision to place GS one-out pending transfer to another correctional centre, Dr Sullivan's view is that this was "not inappropriate" having regard to GS 's level of distress, the urgency of the threat, and the need for staff to respond quickly. However, Dr Sullivan noted that it remains of concern that despite recurrent suicides in correctional settings, there remain cells which are not ligature-free. Dr Sullivan said that if correctional staff had the opportunity to consider the effect of GS 's phone call to his sister on his mental state, he speculates that they may have been more conservative in the choice of placement, though Dr Sullivan acknowledged that this may be an observation based on hindsight.

Impact of frequent transfers between correctional centres

98. Dr Sullivan was asked to comment upon the impact of GS 's frequent transfers between correctional centres. He observed that such transfers are disconcerting for prisoners and may prevent them from developing the routines, relationships and activities that reduce psychological distress and enable better

coping during incarceration. Notwithstanding Justice Health policies on rolling over existing appointments, Dr Sullivan considers it likely that recurrent transfers delayed the potential for GS to be reviewed by a GP and/or psychiatrist. Each time he was transferred to a new centre, staff would not have an appreciation of the cumulative delay and this may have impeded his advance up the queue towards eventual review. Further, recurring transfers reduce the likelihood that staff at one prison can align their knowledge of the waiting list with an individual prisoner known to them, and can then ensure that changes in priority occur when review has repeatedly been deferred through no fault of GS.

Opportunities to enhance access to clinical review

99. Finally, Dr Sullivan observed that based on his retrospective review, the combination of clinics cancelled or unable to meet demand, transfers between prisons and low prioritisation precluded GS from accessing a doctor for medication review. Dr Sullivan says that if a service is driven by reactive prioritisation, patients with chronic mental health conditions will always be less likely to receive services than those who have crises of high acuity. Dr Sullivan suggests that this could be remedied by ensuring that patients with a mental health diagnosis are seen for long-term review at a certain frequency, akin to those with chronic health conditions like diabetes or hypertension, to ensure that non-acute patients are not repeatedly trumped by crises or by more urgent cases.

100. Dr Sullivan noted that Justice Health policies have been reviewed and observes that if these changes in process can be implemented, then the likelihood of recurrently missed clinical reviews will be reduced. In particular, the use of videoconferencing and state-wide demand management may increase access to specialist review.

ISSUES

101. The list of issues in this matter was as follows:

1. Was the mental health screening, monitoring, care and treatment provided to GS at the correctional centres of which he was an inmate from

February to September 2018 adequate or appropriate, including with respect to:

(a) the adequacy and timeliness of any assessment of GS by a General Practitioner and/or psychiatrist;

(b) the adequacy and timeliness of the administration, dosing and review of antipsychotic and antidepressant medication to GS; and

(c) the impact of GS's frequent transfers between correctional centres during the period from February to September 2018.

2. Was the decision of Senior Correctional Officer Luke Stone on 12 September 2018, to place GS one-out in a cell with hanging points, appropriate in the circumstances and on the basis of the information available at that time?

3. Are recommendations necessary or desirable in order to improve the health and safety of inmates at correctional centres in New South Wales?

102. In relation to the issues, it was accepted in submissions that GS was not assessed at any time for an assessment by a GP or a psychiatrist for his mental health. His medication was therefore never reviewed. It was also accepted that he was not given his medication at the time of entering the custodial system, nor for some time.

103. Further, it appeared accepted that his frequent transfers between correctional centres did impact on his mental health treatment, consistent with the expert evidence.

104. It was agreed that SCO Stone acted appropriately in the circumstances, performing his role in accordance with the policies and guidelines at the time.

105. The real issue and focus of the inquest related to whether there are recommendations necessary or desirable in order to improve the health and safety of inmates in the future.

ANALYSIS OF THE EVIDENCE

Evidence of Mr Stone

106. SCO Stone was at the time a Senior Correctional Officer. His role involved supervising staff and inmates, and he had worked at Goulburn CC since about 2007.

107. As at September 2018, he had been a correctional officer for about 15 years, so had a great deal of experience.

108. SCO Stone interacted with GS on 12 September 2018, when GS approached him and was teary and upset. GS told him that he needed to be moved from the yellow yard, which was the most protective area at Goulburn CC, due to threats of harm. SCO Stone accepted his complaint and immediately acted to protect GS. The procedure was to then lock GS in a cell until he could be transferred out of the prison. Mr Stone did not know who was a threat to GS, and in those circumstances he moved him from the two-out cell that he was in and isolated him in a one-out cell for his own safety. This was in keeping with protocol.

109. SCO Stone spoke with GS to ensure that he was happy to be in a one-out cell, and he formed the view based on GS's presentation that he was not at risk of self-harm at that time. On that basis, SCO Stone allowed GS to pack his belongings and moved him to a different cell awaiting transfer.

110. SCO Stone was not aware of the full extent of the relatively upsetting call earlier, nor that it had a significant impact on GS. SCO Stone was also not aware of GS's psychological history or medications, nor the fact that GS had asked many times to be seen by a medical practitioner for his medications.

111. SCO Stone was of the view that he had to treat everyone else as a potential threat until GS's safety could be confirmed. He was undoubtedly comforted by the fact that GS had reported his safety concerns and was in effect acting in a self-protective manner. By the end of their interaction, GS was no longer teary and upset. He was eating his lunch and talking to SCO Stone.

112. SCO Stone's treatment of GS was in keeping with policy. He was conscious to ensure that he believed GS was in good mental health and felt confident that he was.

113. There is to be no criticism of SCO Stone and his action to immediately attempt to protect GS .

114. This is another example of how matters may have been different if all of the information was available to SCO Stone, and how that might have led to additional concerns for GS if the material that was known to Justice Health and CSNSW was brought together. It also highlights that an inmate who is moved around so many times requires the cumulative information to be kept somewhere easily accessible.

Evidence of Mr Murrell

115. Mr Murrell attended to give evidence from the perspective of his previous role as General Manager, State-wide Operations, Custodial Corrections Branch of CSNSW.

116. Mr Murrell was able to give helpful evidence that ligature points are an ongoing matter to be addressed in all correctional centres. In this case, of course there were exposed bars in the cell where GS was placed. He indicated that a joint working group was formed between representatives of CSNSW and Justice Health to be scheduled quarterly. It was unclear on his evidence whether these meetings continued to take place, although Mr Murrell attended an initial meeting.

117. Mr Murrell did indicate that there are now better processes in place to complete a checklist before putting an inmate in a new cell, called an accommodation checklist. However, it also should be noted that the checklist would not have applied to moving an existing inmate within the same complex, such as the decision to move GS into a one-out cell when the allegations of threats were made.

Evidence of Dr Spencer

118. Dr Sarah-Jane Spencer, forensic psychiatrist and Medical Superintendent of Long Bay Hospital provided critical evidence in the proceedings. She agreed that the custodial population has a much higher prevalence of psychiatric disorder than the general community, and a higher prevalence of suicide.

119. In relation to self-referrals to the clinic within the custodial setting, Dr Spencer indicated that there were two mechanisms for this occurring. Either a Patient Self-Referral form could be completed, or the mental health telephone line could be accessed.

120. When self-referring, a registered nurse takes the form and enters the patient on the appropriate clinician's waitlist of the PAS. This is an electronic system that communicates some of the information directly to OIMS, the CSNSW database, which is old and basic.

121. A new patient received into custody who has been on antipsychotic and antidepressant medication in the community can continue the prescriptions if medications have been then reviewed and approved by a GP or psychiatrist, without the need for a face-to-face appointment.

122. Dr Spencer agrees with Dr Sullivan that continuing medication without a face-to-face review should not be a sustained policy. She also agreed that GS should have been seen by a GP or a psychiatrist during his period of incarceration, or, she added, a nurse practitioner.

123. Dr Spencer explained that during periods of lockdown, at times medical practitioners might not have been able to access patients. CSNSW have the ultimate say in relation to movement of patients to clinics.

124. The following exchange took place in evidence:

> "Q. Dr Spencer, I have taken you through the various patient self-referral forms at some length, and also the patient administration system wait list reports. I think it's the case, and in light of those repeated requests by GS to have his medication reviewed, you agree, don't you, that he should have been seen by a GP or a psychiatrist during that period?
>
> A. Yes. Or a nurse practitioner. Yes.
>
> Q. In relation to that view or that conclusion that he should have been seen, there seemed to be - and you can agree or disagree with this - but there seems to have been a number of steps along the way, or junctures which

dictated whether or not he could in fact be seen. I'll suggest these to you and let me know if you agree or disagree. One juncture along the way that dictated whether or not he could be seen was actually being placed on a relevant wait list?

A. Yes.

Q. Another was the question of which clinical priority category he was allocated to?

A. Yes.

Q. Another was the way that the wait list in question was made, including monitoring, for example, an overdue appointment?

A. Yes.

Q. And perhaps an appreciation of the cumulative requests that GS had made for review?

A. Yes.

Q. Then finally, the actual triaging of patients on the ground, and the decisions on a day-to-day basis around who will and will not be seen off the wait list?

A. Yes.

Q. You've given evidence that GS should have been seen. Sitting here now and based on your review of the records, are you able to offer a view as to where the missed opportunity lay in GS 's case? Whether it was in any of those stages that I've identified, or anywhere else along the way?

A. I think unfortunately it was probably at multiple … stages. I think one of the key issues perhaps that you haven't emphasised is the huge challenge with resourcing in custody. And I think that's been well recognised in this Court and continues to be, continues to come up. We've just actually had a psychiatry workforce review done by external parties to Justice Health, and they commented how stark the resourcing in the New South Wales is, as compared to other states in Australia, and that's one of the huge challenges that I think impacts on patients accessing timely care, and unfortunately does

lead to a system where those who are the most urgent get seen. I do think there was a missed opportunity to re-prioritise GS to a higher priority on probably a number of occasions as he kept requesting to be seen.

I think it probably is important to mention that there is unfortunately a level of - I guess I'd call it learned helplessness from the staff working in custody from a health perspective. That they know they're under-resourced, and it's pretty difficult to keep getting requests from patients who you know need help, and you know that you're not going to be able to help them because there just aren't enough hours in the day when you're able to access patients and enough people to see them. So there is a bit of self-protection where you just kind of look, and they're on a waiting list, and something is being done, but it is pretty difficult to keep working knowing that you're always going to sort of be failing because there just aren't enough staff to go round."

125. Dr Spencer was asked about improvements and changes that she is seeing within the system. She said this:

"A. I think there's a number of things happening. One of them is the development of a sort of targeted education, particularly to the mental health nurses in the first instance, and then the plan is going to be to roll it out to the primary health nurses as well. To focus on triaging in particular. And I think it's probably fair to say that historically there hasn't been - it hasn't been on everyone's mind, the need to effectively manage wait lists, in part because of the resource difficulty, and the fact that everybody is struggling to juggle that, but it's very much an organisational priority now, and that's filtering down to the whole team. So, ….., they're approaching it in multiple ways. Some of it is the PAS project, some of it is education and targeting the mental health staff in the first instance, and then more broadly to the primary health team as well.…

Q. Can you explain to her Honour what is the PAS project?

A. So, I think it's been well recognised for some time. It's a really old system and it's very clunky, and there's lot of feedback from the staff who use it that it

is inefficient, difficult to use, and yeah. Sometimes it feels not really fit for purpose, but we are a bit stuck with it, because it communicates with OIMS. And so there was an undertaking to review PAS, how we work with it, in an attempt to do what we can to make it more efficient, bearing in mind that we can't overhaul the whole systems. So we're sort of working with what we have, but trying to make it more user-friendly, basically."

126. Dr Spencer was asked about the frequent transfer of GS :

"Q. In your view would that still be the effect of frequent transfers of a patient like GS today, in light of things like the waiting list app and the centralised analytics reporting portal you've given evidence about?

A. It's - it's still disruptive, moving centres, but yes, those things have been put in place to try and minimise that disruption, but from a mental health perspective we try and have a model where it is the same clinicians looking after the same centres. So if you are moved to a different centre then you're going to be seeing a totally different team, and that is a - that's not ideal in terms of continuity of care.

Q. You also agree with Dr Sullivan that it's likely that a psychiatric review of GS would have led to his medication regime being reviewed and potentially altered?

A. Yes."

127. Dr Spencer agreed that perhaps a new category would be helpful, for those who fall into category 3 but have not been seen and have made multiple requests. Finally, she noted that there was enough information to suggest that GS GS should have been seen, and an error was made.

128. In relation to multiple requests made by inmates, Dr Spencer did urge caution in merely creating a heightened category on that basis alone, as some patients may have cognitive and other difficulties which result in many such applications being made.

Evidence of Associate Professor Sullivan

129. Dr Sullivan provided an independent review of GS 's case. He raised a number of very valuable insights into GS 's management. He was able to say, as an experienced practitioner in custodial settings, that GS should have been seen in the custodial setting for the changes to his medication that he was seeking.

130. Dr Sullivan indicated that correction would have been made to both of GS GS 's medications if he had been reviewed by a psychiatrist. It is likely the dose of Sertraline would have been increased to between 150 to 200mg by a psychiatrist. Dr Sullivan also notes that he had concerns about the prescription of the Quetiapine, and would have most likely discontinued that prescription.

131. Dr Sullivan was taken to the issue of the level of resourcing and the acuity of the need of the individual. He gave the following evidence:

> "Q. And the result is that patients with chronic mental health conditions will generally be less likely to receive services than those who have a crisis of high acuity?
>
> A. Yes, that's right, you have to be cautious that you're not always seeing the people who are yelling the most loudly and you need to be aware that there are a number of prisoners who are sitting quietly, psychotic and not raising any attention within the prison, or you have chronic low grade mood disorders which need attention and would benefit from attention but never seem to get to the top of the queue or don't actually appear as urgent as someone more pressing, so it's really a matter of balancing all of that workload and not simply being hypnotised by the most urgent or acute cases.
>
> Q. And you say - this is still in paragraph 121 - you say that this could be remedied by ensuring that patients with a mental health diagnosis are seen for long-term review at a certain frequency. Can I ask you, first of all, in the case of those patients with a mental health diagnosis, what sort of frequency of review do you consider would be appropriate?
>
> A. Look, I'd generally say around sort of six months. In some cases you can have a more frequent review. In the community, for instance, the average

script lasts for a month and you have five repeats, so that's clearly geared towards ensuring that every six months you need to trot back to GP or prescriber in order to update the prescription and just for the GP to cast an eye over you and ensure that any monitoring that's needed is done, that any adverse effects are addressed, that compliance is addressed, that dosage can be tweaked.

So six months seems a reasonable period of time. As well as that, obviously you need mechanisms whereby people who are not benefitting from medication or who are deteriorating or experiencing adverse effects can receive a more urgent response, but for the majority of people who might be on a long-term medication, who are stable but of course the medication is implicit in maintaining that stability, ideally you want them to be reviewed regularly just to ensure that the medication is at the appropriate dosage, that you're looking after their general health and that you're simply not repeating the script without ever seeing them again."

132. Dr Sullivan was asked to comment on his clinical experience in custodial settings and generally in the field. He said:

"A. I certainly appreciate and agree that resourcing clinical resources in Correctional settings are limited, in particular of psychiatrists and that there is a vast degree of need. I think, however, that what that requires is perhaps there's an increased - perhaps a smarter use of resources that involves the use of GPs perhaps a little more than is already done and there's often an implicit separations of responsibility for psychiatric medications between GPs and psychiatrists based upon the comfort of the general practitioner, their level of attachment to a particular Correctional centre so that they have a knowledge, an oversight, of the prisoners there and don't simply just do a rostered shift here or a rostered shift there.

I would also say that it doesn't need to be particularly onerous. In many cases that review can be done by a mental health nurse, but what it does require are protocols for escalation and where necessary, I think at least every six months, a prescribing clinician should at least meet the person face

to face and endeavour to ensure the appropriateness of medication."

133. In relation to the better use of resources, Dr Sullivan provided the following:

"A. Yes, absolutely and nurse practitioners. In Victoria we have over the last ten years trained a number of nurse practitioners. They've been a really welcome addition to the mental health workforce in prisons. They have all of the skills of nurses and the caring and empathy and the ability to build relationships with patients, combined with the ability to prescribe in a Correctional setting so we've certainly seen that in the Victorian system the use of nurse practitioners has been really helpful and really effective.

Having said that, given the resourcing often is concentrated in a few specific prisons, which is appropriate, where you can actually concentrate the expertise and transfer prisoners with high levels of needs to those places, the resourcing becomes more of an issue as one heads further away from those centres, and then psychiatric clinics become more infrequent. There are restrictions on the use of registrars or doctors under supervision who often can't actually see patients without a supervising consultant psychiatrist being on the premises, so it becomes a little more difficult to use your training workshop - workforce - more smartly, so I think GPs and nurse practitioners become a better option for review. That way you have a tiered protocol which means that as happens in Justice Health and the Forensic Mental Health Network, nursing staff lead the service, review the patients and determine categorisation and prioritisation and then they determine the appropriate referral source based upon a dynamic understanding of what's available, what the waitlists are like and they also can ensure that the person is seen by - whether it's a GP or a psychiatrist; in some cases I suspect that psychiatrists see patients who could very adequately be managed by GPs but it's seen as, I suppose, perhaps part of the psychiatrist turf.

I don't have ready answers to the resourcing allocation except to say that I think that the way in which Justice Health allocates its resources is very equivalent to Victoria and to other services, which seek to use that hierarchy

of expertise and rarity to make sure that the right patients see the right professional at the right time."

134. Dr Sullivan was asked to comment on the better use of telehealth to access more patients and he gave the following response:

> "A. Yes, absolutely. For many patients Telehealth really increases the access to professionals. There's potentially a small loss of rapport and possibly a small loss of the capacity to assess some of the finer elements of mental health disorders and that's particularly the case for perhaps psychotic illnesses, but for mood disorders, so long as you can combine it with a remote specialist and then someone on the ground who's able to implement those things, so often having Telehealth with the nurse in the room, then being able to carry forward and ensure that the scripts are written up, that the patient gets them, that they receive printed information about new prescriptions and have an opportunity to answer any questions afterwards.
>
> So I think there are certainly ways that that reduces, certainly from my experience, you know, driving two and a half to three hours to a country prison eats into your clinic time, if you have to drive back that day, and for some of the more remote prisons it means that you have very limited numbers of clinics, whereas Telehealth increases the frequency of that."

135. Overall, Dr Sullivan notes that GS did not receive appropriate mental health monitoring, care and treatment during his imprisonment in 2018 and I accept this evidence. On these important points, Dr Spencer, another eminent psychiatrist who understands and is experienced in the custodial setting agrees.

136. Dr Sullivan noted that prison health services aspire to equivalence with the community standard, or in some cases may seek to exceed that standard due to the exceptional healthcare needs of prisoners. Neither of those standards of service were provided to GS.

137. Dr Sullivan noted that it was inappropriate in the custodial setting that GS GS's community medication could not be clarified, reconciled, confirmed and continued. Dr Sullivan noted that the effectiveness of medication such as

antidepressants relies upon continued rather than intermittent dosage.

138. Dr Sullivan could not determine that the absence of medical review contributed to GS 's death. However, Dr Sullivan did state that:

> "… there is a reasonable possibility that his mental state would have been clarified had a management plan put in place, had he been reviewed by the GP and particularly if seen by a psychiatrist or registrar. This opinion is based upon the clear evidence that GS considered that his medication regimen was not meeting his needs, and his repeated requests for its review. Ongoing action to improve his mental state would almost certainly have required alteration of medication, and potentially sustained nursing or psychological intervention."

139. Further, Dr Sullivan noted:

> "Transfer between correctional settings is disconcerting for prisoners and may prevent them developing the routines, relationships and activities that reduce psychological distress and enable better coping during incarceration. The rationale for various moves was not clear and may have related to classification, SMAP issues, and in at least one situation, transfer to complete a psychiatric court report.
>
> Notwithstanding JHFMHN policies on rolling over existing appointments, I consider it likely that recurrent transfers delayed the potential for GS to be reviewed by a GP and/or psychiatrist. While he remained on the non-urgent list, each time he was transferred to a new centre, staff would not have an appreciation of the cumulative delay, and this may have impeded his advance up the queue towards eventual review. Furthermore, recurring transfers reduce the likelihood that staff at one prison can align their knowledge of the waiting list with an individual prisoner known to them, and can then ensure that changes in priority occur when review has repeatedly been deferred, through no fault of GS ."

140. Further, Dr Sullivan stated:

“Prior to incarceration, he had established diagnoses of substance use disorder and mood disorder, and it is reported that he had had several admissions to public and private hospitals related to acute mental health concerns. He entered prison on prescribed psychiatric medication. This history places GS in a category of prisoners with a higher likelihood of meeting mental health diagnoses and thus warranting medical review. His history of self-harm and suicidal ideation places him at increased lifetime risk of death by suicide. However there are no specific assessment tools or ‘high risk’ items that are specifically predictive of completed suicide.

In some prison health systems, a review based on his mental health history might be conducted by a general practitioner, but in my opinion the initial or comprehensive review should be conducted by a psychiatrist. Psychiatrists have specific skills and training in the holistic assessment of the patient, including interactions of mental health with medical or physical health conditions, and substance use disorders. Psychiatrists have specific expertise in the adjustment and alteration of medications when indicated. In a prison setting, it is usual for a GP to continue existing medications, occasionally to initiate medications, but most cases to seek psychiatric consultation when serious mental illness maybe [sic] present.

In my opinion, a man with a reported, documented history of migraine, who was complaining that he needed treatment for this, should have been assessed by a general practitioner.

His repeated requests for medication review were appropriate and yet on my review of the records, I cannot find evidence that he was reviewed by a medical practitioner, either a GP or psychiatrist, at any stage. Only a general practitioner or psychiatrist (or nurse practitioner) would have been in a position to adjust his medication.

The psychiatrists who continued medication on drug charts did not have the benefit of face-to face assessment and from that perspective, it is difficult to justify adjustments in medication or dosage without having assessed the patient. While continuing medication, without a face-to face review, may be

practicable in the short-term, it should not be a sustained policy.

It is my understanding that the JHFMHN functions on a nurse-led system. This is cost-effective … ."

141. Dr Sullivan raised the good use and engagement of nurse practitioners. Dr Spencer echoed the use of these resources, however noted that funding is currently an issue with engaging more nurse practitioners.

Reflection on the evidence

142. There is no doubt that GS 's mental health was not treated appropriately in custody. I find this based on the expert review of the material. I am also satisfied this occurred as a result of non-compliance with policy, which dictated that GS ought to have been seen by a medical practitioner at a minimum of 14 days to 3 months, and he was not.

143. Further, I note that there was non-compliance with policy to ensure GS had access to medication that had been prescribed to him prior to entering custody. It took almost one month to remedy that situation, even given two RITs and serious concerns for his mental health, and that he echoed the need for his medication.

144. There was evidence about usual practice here, and the fact that resources might only allow review after 6 months. There was also evidence about the implementation of a new call-up system to self-report. Those issues do not have much bearing on GS 's case. He was a person who succinctly and articulately followed the available procedure to seek help and was not helped.

145. GS provided the following cries for help:

- On 23 February 2018, he requested, "I need to see the doctor". GS noted he had been asking since 8 February 2018 for his medication. He said "This is causing serious distress - lack of sleep, issues with emotional processing etc. Also, migraines are recurring. I need to be assessed for Panadol at least".

- On 25 February 2018, GS was placed on a MNF. During the RIT assessment on 27 February 2018, he was teary and reported “it would not have happened if he had his medication earlier”.

- On 29 April 2018, GS completed a Patient Self-Referral form in which he stated: “I request to see a psychiatrist to review medications I receive for depression [and] anxiety” and “I am having trouble with feeling agitated and depressed and having some trouble sleeping, an increase in Zoloft [and] Seroquel would help.” He was noted to already be on the psychiatrist referral list.

- On 30 April 2018, GS completed a Patient Self-Referral form in relation to headaches. In response, no action was taken and no paracetamol given.

- On 9 May 2018, GS self-reported that “I need psych medication review – still agitated and difficulty sleeping.”

- On 20 June 2018, GS completed a Patient Self-Referral form and stated: “I need to see psychiatrist to get antidepressant and mood stabilizers [sic] reviewed. I am having great difficulty sleeping and have been depressed. Likely need increase of Seroquel and Zoloft. I am only on low – starting doses.”

- On 4 July 2018, GS completed a Patient Self-Referral form in which he stated: “I need to see a doctor/psychiatrist to review psych meds and I can’t sleep and am agitated and want to be stabilised prior to release …”. A note is made by a nurse that he is asking to be placed on a waitlist that he is already on.

146. GS made five patient self-referrals specifically seeking review of his medication. Nothing happened.

147. This evidence demonstrates a failure that has not readily been explained in this inquest. In a situation where an inmate cannot self-access medication, a GP or a psychiatrist, it is of great concern that these things are not reasonably

provided when they remain in the full responsibility of CSNSW and Justice Health. GS could not even easily obtain Panadol.

148. It was the nature of the system that he was constantly being moved around, he had no control over that. He had little stability, a known mental health diagnosis, difficulty making friends and fitting into custody, previous self-harm attempts in custody, he had been placed on two RITs in a short period of time, he was reporting medication was not working and it was known that he had at least once attempted to even self-medicate in the end by trying to obtain illicit substances. He was distressed at the thought of being refused bail and being kept longer in custody. He was then threatened, placed in a one-out cell, and ultimately ended his own life.

149. Submissions were made that much of this was with the benefit of hindsight, however, this was all information known and within the records of CSNSW and/or Justice Health. There appears to be significant communication failures between the two.

150. I turn to the recommendations and discussion of the same below. Justice Health, submitted that none of the proposed recommendations should be made, and that the Court should be comforted by the measures already taken. Some five years later most of the steps relate to pilot programs, or programs that reach some of the correctional facilities but not all, and no evidence of significance systemic permanent change.

151. In documents from Justice Health, the following information is provided:

> "We form a vital component of the NSW public health system through its support of a highly vulnerable patient population whose health needs are often numerous and more complex than the wider community.
>
> We are positioned with a unique opportunity to respond to the health needs of these individuals who commonly have had minimal contact with mainstream health services in the community. We care for over 30,000 patients annually, a health community that is unique in NSW."

152. This appears to recognise the increased needs of the prison population, and the complexity of the issues are more complex than in the wider community.

153. The statistics provided appear to suggest that a person in Justice Health care is 2.5 times more likely to have a mental health condition than the broader community.

154. Indeed, mental health treatment in custody assists in many ways. The individuals are vulnerable, and the confines of the prison environment would seemingly not better improve mental health unless treated appropriately. If someone seeks and wants help, it should be as readily available as possible. This not only assists the individual but also the community, enhancing and supporting rehabilitation, and is therefore a protective community factor.

155. The other obvious matter is that the staff working within the prison system, both the Justice Health employees and CSNSW employees, are committed individuals, working in a difficult environment, and yet they too are left seriously exposed to outcomes such as GS 's and should be thought of and protected.

REFLECTION ON ORAL SUBMISSIONS BY PARTIES ON THE EVIDENCE

Justice Health

156. On behalf of Justice Health, it is noted that mental health screening occurs when a patient is received into custody initially, and not on transfer between the facilities. It was accepted that there were five appointments made for GS that were cancelled as a result of lockdown or general practitioner illness, not as a result of any fault of GS . The explanation for GS not being seen was due to unforeseen circumstances, including technical difficulties, illness of the reviewing clinician and unscheduled lockdowns. He was also, according to the wait list report on 21 June 2018, removed from the wait list to see a GP after 99 days. There has been no explanation as to why this occurred.

157. It was submitted that seven reforms have resulted in an improved system in the last five years. The first is a business rule entitled "Management of Patients

who do not attend booked patient administration system appointments". The name suggests that it is the patient who does not attend, unlike in this case, however it is submitted that what will occur now is that the appointment cannot be cancelled without direct communication with the patient and presumed rebooking of appointment.

158. The second is that a weekly audit report is generated of all overdue PAS wait list patients, distributed to custodial mental health staff. Dr Spencer indicated that this is used to identify patients nearing the end of their timeframe for review and mental health nurses in the clinics can use that information to prioritise patients for clinics on the ground level. It should be noted here that there is no evidence as to what a mental health nurse (if there is one available in that facility) should do when there remain significant competing interests for higher category patients and the availability of resources.

159. Further, Dr Spencer gave evidence that since its introduction in October 2022, there has been a reduction in the number of patients who are not being attended to in the appropriate time frames. It was submitted it has been a success. When asked how significantly it has improved, it was indicated that information can be provided, however it was not received in evidence. The idea of data collection is an excellent improvement, but it is unclear how this is impacting on practice and procedure, particularly relating to the lower categories 3 and 4.

160. The third improvement is the introduction of electronic medical records, which allows nursing staff triaging self-referral forms to quickly access previous self-referral form on JES. Dr Spencer gave evidence that a number of self-referral forms having been completed was a matter that should be taken into account in triaging a patient's need for review, and that is accepted. However, in this matter it is also submitted that there is no evidence to suggest these previous self-referral forms were not considered. In fact, on several forms it is was noted that he was already wait listed.

161. The fourth improvement is said to be the PAS project commencing in February 2022. As part of that project, Dr Spencer said there is a review of protocols which would be relevant to GS 's case. For example, she

identified that category 3 was being reviewed to determine whether it remains an appropriate category. It would seem that the factual scenario in this case is excellent evidence to assist such a reform.

162. The fifth reform is a that a targeted education program is being rolled out to mental health nursing staff, focussing on appropriate triaging. Once completed, it will then be rolled out to primary health care nurses. I note that this is in progress. Again, GS 's matter would be useful as a good example of what to do when a patient continually is not seen and falls well outside time frames.

163. The sixth reform is a self-referral form review. This is a move to a call centre, with a pilot that commenced in January 2023. Although a very good proposal, it is of note that GS was able to adequately complete the forms and they came to the attention of staff who were aware of his previous self-referrals. At this stage, this is also a pilot trialled in six correctional centres and was due for review in June 2023, and not implemented globally.

164. The seventh is the engagement of nurse practitioners. Although they have been engaged, it was clear on the evidence of Dr Spencer that more are needed and that resources remain thin.

165. Overall, it is clear that the staff of Justice Health and in particular the work of Dr Spencer is admirable, to advocate for improvement and change. It is also clear that this is a very slow process, and many of the reforms are still pilots, or remain under investigation and review to date. There was little evidence of actual permanent change.

166. GS was the worst-case scenario, in that he is now deceased. The concern remains for other inmates who remain in category 3, who may be suffering mental health anguish unnecessarily as a result of the resourcing being insufficient and category 1 and 2 overtaking them.

167. The issue of the PAS reports and overdue waitlist reports was very helpfully raised by Dr Spencer, and she indicated that it was an available document It was referred to in submissions and again I was informed that could be provided. That was not provided in written submissions, even though submission relied upon this

new change. As a consequence of the submissions, I requested the document and have been provided with the same. The PAS report did not have the benefit of commentary and evidence from Dr Spencer to assist me, but on the face of it there is an alarming number of category 3 patients who remain unseen within the desirable timeframes, some 198 people in fact, and many waiting well beyond proposed wait times. This is of great concern. Reading the reasons for some of those requests indicate that some may relate to patients seeking medication adjustments. It is clear from that report that it is unknown how many requests have been made by the individual patient.

Submissions for the Commissioner of CSNSW

168. The submissions on behalf of the Commissioner of CSNSW noted that Ms Flight provides a statement about why inmates are moved around. In 2018, it was submitted there were over 35,000 new receptions into custody and a similar number moving out of custody. The usual number within the prison population was 12,500 people at any one time, and that demand requires that those inmates on remand are moved around. There are other reasons like facilitating court, legal appointments and medical appointments. There is no suggestion that the proper processes were not followed each time GS was moved.

169. It was submitted on behalf of the Commissioner of CSNSW that there could be no criticism of CSO Stone, and I agree. He actioned the complaint immediately and dealt with the threat.

170. In relation to ligature points, my attention was drawn to Mr Murrell ‘s evidence and the long history and large operation that CSNSW have been involved in to try and eliminate hanging points. Assistant Commissioner Craig Mason raises improved prison initiatives, involving purpose designed furniture, retirement of older prisons and refurbishment of 157 cells. It is noted that it is not perfect, but works are continually undertaken to improve this situation.

Submissions for Mr Stone

171. I accept the submissions on the part of CSO Stone. They note that he only knew the information he had at the time of making the decision to place GS in a one-out cell.

172. On behalf of Mr Stone, a policy that Justice Health assessment is undertaken in cases where there are threats of personal physical violence necessitating the removal and isolation of the complainant is embraced, in the hope that this may provide a further safeguard for inmates in those situations facing a move.

PROPOSED RECOMMENDATIONS

Recommendation one: That Corrective Services NSW (**CSNSW**) and the Justice Health and Forensic Mental Health Network (**Justice Health**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at the existing correctional centre, and who are in one-out cell placement pending transfer, are to be referred to Justice Health for assessment.

173. This recommendation is helpfully internally suggested by and agreed to by the Commissioner for CSNSW and will be made. I was informed that this was consented to by Justice Health, and submissions by Counsel Assisting raised this issue on 15 June 2023 noting that it had been agreed upon. On 13 July 2023, Justice Health advised that it had not agreed to the making of the recommendation in relation to it. There appears to have been a misunderstanding.

174. It appears a necessary and desirable recommendation, and CSNSW is embracing the consideration of it. It is desirable that Justice Health also consider this recommendation, to ensure that a process is developed to make it work. This is an example of where the two organisations need to work together. I intend to make this recommendation.

Recommendation two: That Justice Health examine the Patient Administration System (**PAS**) Waiting List Priority Level Protocol and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

175. This is not supported by Justice Health on the basis that it is not necessary and may be risk adverse to patient health outcomes. It was submitted on behalf of Justice Health that this recommendation was contrary to Dr Spencer's evidence. As set out above, I find the evidence does not support this position. Dr Spencer noted the potential for consideration of a further category where a person has been waiting to access healthcare. She raised the issues of individuals with intellectual disability or cognitive issue putting in multiple forms, neither of which was applicable in this case. GS followed the only process he could, in an informed, reasoned, knowledgeable and articulate way. It is clear that when a person who is in the hands of the prison system follows the procedure, the process should have to be answerable when it fails, as it did here.

176. The submissions on behalf of Justice Health note that waitlist management has been identified as an organisational priority by Justice Health, and that there is a targeted education program with a focus on effective triaging of patients. There is no evidence that this addresses the failure in this case. The submissions on behalf of Justice Health note a roll out of an electronic medical records system has improved access to relevant clinical records, yet it is also submitted by Justice Health that the evidence in this inquest did not support a finding that nursing staff were not accessing self-referral forms in triaging GS GS. I agree with that submission. There are active piloting improvements occurring some five years later and in particular self-referral for medical issues via telephone. This was not an issue in GS's case, his words and needs were clear. PAS Category 3 is considered very broad and is actively being considered. This recommendation appears to be an opportunity to encapsulate the failures in this case.

177. In relation to this recommendation, it is simply asking that while PAS is being reviewed, there may be a way to ensure consideration is given in cases where there are multiple requests, as occurred here. That would not prevent staff exercising discretion in the types of cases that Dr Spencer mentioned, but may be an opportunity to catch the quiet and cooperative inmates who may otherwise continue to fall through cracks.

Recommendation three: That Justice Health consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

178. This is not supported by Justice Health as necessary or desirable to improve patient health outcomes. Dr Spencer noted that the PAS reports that she was taken to did not present in the manner PAS presents in real time. The submission was made on behalf of Justice Health that PAS is a medical booking system, used to book appointments for patients from the waitlists that they have been placed on.

179. It is noted however in Justice Health's submissions that "Justice Health NSW is, however, undertaking system change that is similar in effect to the recommendation proposed". It also is noted that there is a current pilot which notes this possible addition. There is provision for the Patient Self-Referral RN to make a record in the PAS appointment list recording receipt of subsequent calls from a patient of the same concern, where a waitlist is already existing.

180. On that basis, it seems relevant and necessary to make the recommendation, to give support to the current pilot, which is just that at the moment, and was due to complete at the end of June 2023, and encourage this system to be put in place beyond the pilot.

Recommendation four: That Justice Health consider extending the provision of telehealth services of General Practitioners, psychiatrists, nurse practitioners and mental health nurses to additional correctional centres in NSW.

181. After consideration, this is no longer proposed by Counsel Assisting and I agree with the various positions on this matter.

Recommendation five: That Justice Health consider amending the PAS Waiting List Priority Level Protocol to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the PAS Waiting List Priority Level Protocol) and who are therefore overdue for assessment.

182. This is not supported by Justice Health and the submission is made on behalf of Justice Health that a patient being overdue for assessment does not necessarily increase a patient's acuity unless their condition has deteriorated in the intervening time. This submission seems to fail to have regard to the very existence of the timeframes. It also does not address the evidence of Dr Sullivan nor Dr Spencer. A person is at greater risk the longer that they are not seen. The recommendation is to assist staff in knowing what to do in these situations. As Dr Spencer noted, staff become despondent in not being able to treat people within a timely manner, merely having the option of putting them on the waitlist again. Some proactive guide to help ensure a person is actually seen is needed. This recommendation is aimed at assisting both the patient and the staff who are ultimately responsible for the decision. It must be a great weight on them to know that a person is not being seen, but they are unable to triage the patient to a higher level. Professional guidance would assist. After this inquest the question still remains – If a patient presents as GS today, what should the staff do in this situation?

183. The generating of reports identifying patients not seen within priority levels are one thing, and knowing what to do with patients is another.

Recommendation six: That Justice Health consider clarifying section 5.3 of the Guidelines for Psychotropic Medications 2020 by specifying that, if a mental health patient on long term medication has not had a face to face assessment of their medication by a General Practitioner, psychiatrist or nurse practitioner in the last six months, then the patient is to be prioritised for immediate face to face review by same.

184. The recommendation is not supported by Justice Health, and issues are raised that to mandate such a requirement might not be possible. Dr Sullivan notes that the current guideline was slightly more extensive than exists in Victoria. He did not suggest it was deficient or required amendment.

185. Counsel Assisting notes that this would address a lacuna in the existing Guidelines. I note that one of the conditions for rewriting a long-term drug chart without clinic review is that there is evidence the patient and their medications

have been reviewed in the previous 6 months. I accept by its silence that the guideline does not support a rewrite of a long term drug chart in those circumstances. In other words, unless a patient is seen at the six months stage, a practitioner is not exercising desired best practice by continuing the medication, patient unseen.

186. On the basis of the expert evidence on this point, I do not propose to make that recommendation.

Recommendation seven: That Justice Health conduct an audit every three months to determine:

(a) the average percentage of patients at each correctional centre in NSW who are seen off each of the GP Primary Health waitlist, the Primary Health Nurse waitlist, the Adult Ambulatory Mental Health Nurse waitlist and the Psychiatry waitlist within the timeframe corresponding with their clinical priority category (as set out in the PAS Waiting List Priority Level Protocol);

(b) the average number of patients at each correctional centre in NSW who are on a GP Primary Health waitlist, Primary Health Nurse waitlist, Adult Ambulatory Mental Health Nurse waitlist and Psychiatry waitlist; and

(c) the average wait time at each correctional centre in NSW for a patient on a GP Primary Health waitlist, Primary Health Nurse waitlist, Adult Ambulatory Mental Health Nurse waitlist and Psychiatry waitlist,

and report back to Custodial Mental Health management and any relevant oversight body regarding the results of such audit.

187. This recommendation is not supported by Justice Health on the basis that from 5 September 2022, Custodial Mental Health began a weekly audit of overdue patients in an "Overdue PAS Summary Report." This report is generated in addition to the CARP overdue waitlist reports in respect of specific patients, which I note appears to be weekly for category 1 and 2 patients and fortnightly for category 3 and 4 patients. The results are presented in a graph and broken down to Priority 1, Priority 2, and Priorities 3 and 4 over periods of time.

188. I was not provided with a graph version of the results. The Excel document that I was provided with raised concerns, as outlined above. There appears some 200 persons on the category 3 and 4 waitlist remain outstanding and have not been seen within the recommended period, many well beyond the period and even beyond GS's wait. Of these, 3 individuals were category 4, with 197 being category 3. Some 62 people were waiting on the category 2 waitlist, again well beyond the 3 days to two week period in which they are to be seen. These are lost opportunities to help stabilise and address mental health of a vulnerable group of individuals. This is also of great concern that these persons could currently be experiencing psychological distress.

189. Counsel Assisting makes a strong case for this to attempt to bring to the attention of Justice Health the patients who are still not falling within the relevant time frames.

190. The concerns raised on behalf of Justice Health relate to requiring another reporting system, with additional resources when it appears that at this stage the data is now at least available and being regularly reviewed. It was also raised that there is cross over between a person being placed on a health waitlist as opposed to the mental health waitlist.

191. Listening to the concerns that Justice Health raises, I will not make this as a recommendation, but rather hope that Justice Health does have regard to what is being done with the figures that are being gathered, because undoubtedly such figures will be called for in the future if similar issues arise. In that regard I will direct that a recent set of findings be sent with these findings to Justice Health in relation to the waitlist, as this is not an isolated event nor outcome.

192. I do intend to make a recommendation which is also opposed by Justice Health.

193. The data provided raises significant concerns that currently on the Custodial Mental Health overdue waitlist report there are 320 people who have not been seen for mental health issues within the guideline time frame. Some of the wait times are extremely overdue. I do reflect however, that this is raw data, that I have not had the benefit of direct evidence on, and that it is one snapshot of

present circumstances. I appreciate there is limited weight I can give to that information, and that there may be further explanations available not the subject of evidence in these proceedings. However, it is the only evidence I have on this issue to assist in understanding Dr Spencer's evidence. At a minimum this new information is evidence to support the fact that change is still required.

194. This recommendation goes a small way to addressing the issue of category 3 as opposed to category 4 waitlisted patients, category 3 being the major focus of this inquest. From the limited documentation that I have been provided, it appears the reporting structure on PAS combines non-urgent (3) and routine (4) patients and identifies non-compliance with timeframes. Looking at the limited data I was provided, 197 were category 3, with only 3 cases of category 4. To draw the distinction between them, and highlight the largest group not being seen within timeframe, the recommendation is this:

That Justice Health, considers clearly separating the current reporting of overdue patients on the "Overdue PAS report" into discrete individual clinical priority categories to allow proper analysis of the delays experienced particularly by inmates currently delayed on the waitlist, category 3.

Recommendation eight: That St Vincent's Correctional Health (**SVCH**) examine the policy titled "St Vincent's Correctional Health: Triage and Priority Waitlist" and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

195. Submissions on behalf of SVCH raise implementation issues surrounding this recommendation. It is said that SVCH does not have access to information regarding custodial patients who are or will be on long term remand, making decisions about a patient's long-term care difficult. The average stay at Parklea CC is 34 days, and patients enter and exit Parklea CC at a far greater frequency than at other correctional centres in New South Wales.

196. Given the high volume of prisoner movement, SVCH is said to face additional pressure if patients on a waitlist are "bumped up" a priority category solely as a

result of repeated agitation for review.

197. This seems to fail to understand the overall problem in the custodial setting. It is not about the number of referrals that have been placed, it is about the failure of the overall system to comply with the timeframes. It is also a process of fairness to all inmates, those who are stationary in one facility and those who are moved around. It is also to recognise that a patient may be in significant distress if they are requesting on numerous occasions for assistance. For the same reasons outlined earlier and for consistency for all inmates, I intend to make this recommendation.

Recommendation nine: That SVCH consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

198. I note that St Vincent's Correctional Centre did not agree to this recommendation.. Their submissions note that this is problematic, and helpfully set out information relating to PAS. However, as set out above, it is the case that this is an issue Justice Health is currently looking to implement, and this recommendation will be made for the reasons previously set out.

Recommendation ten: That SVCH consider amending the Triage and Priority Waitlist policy to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the Triage and Priority Waitlist policy) and who are therefore overdue for assessment.

199. I note the objection set out in the submissions, and the concern about implementation of the same. I note also that it is submitted that this issue is to be reviewed next year in June 2024, and it is noted that these recommendations will be considered, but guided by feasibility issues. It appears to be acknowledged therefore that changes are needed, and in accordance with my earlier consideration and for those reasons, I intend to make this recommendation.

Recommendation eleven: That SVCH consider amending the policy titled "Correctional Health: Primary Mental Health Management Procedure" by specifying

that custodial patients with a mental health diagnosis who are on long-term psychotropic medication must have a face to face clinical assessment of their medication by a General Practitioner, psychiatrist or nurse practitioner at least every 6 months.

200. I note the objection taken to this recommendation, and for the reasons provided earlier I do not intend to make this recommendation.

Recommendation twelve: That SVCH conduct an audit every three months to determine:

(a) the average percentage of patients at Parklea Correctional Centre who are seen off each of the GP Primary Health waitlist, the Primary Health Nurse waitlist, the Adult Ambulatory Mental Health Nurse waitlist and the Psychiatry waitlist within the timeframe corresponding with their clinical priority category (as set out in the Triage and Priority Waitlist policy);

(b) the average number of patients at Parklea Correctional Centre who are on a GP Primary Health waitlist, Primary Health Nurse waitlist, Adult Ambulatory Mental Health Nurse waitlist and Psychiatry waitlist; and

(c) the average wait time at Parklea Correctional Centre for a patient on a GP Primary Health waitlist, Primary Health Nurse waitlist, Adult Ambulatory Mental Health Nurse waitlist and Psychiatry waitlist,

and report back to management and any relevant oversight body regarding the results of such audit.

201. As outlined above and for those reasons, I decline to make this recommendation.

Recommendation thirteen: That the GEO Group Australia Pty Ltd (**GEO Group**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at Junee Correctional Centre, and who are in one-out cell placement pending transfer, are to be referred to health staff for assessment.

202. I note the objection to this recommendation by the GEO Group. GEO Group operate and provide health care services at Junee. This is an area that CSNSW have indicated does require review, and GEO Group as a custodial operator should be involved in considering this recommendation. GS 's matter, highlighted that no one person had all the relevant information at the time of his placement. Dr Sullivan highlighted the stressors involved in moving to a new complex, particularly given that GS had been moved several times previously.

203. SVCH has not adduced any information to support the nature of the additional pressure, and in any event it would be the case that if is being embraced by CSNSW so in turn will be embraced by MTC and the two should work together on this recommendation.

Recommendation fourteen: That Management & Training Corporation Pty Limited (**MTC**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at Parklea Correctional Centre, and who are in one-out cell placement pending transfer, are to be referred to SVCH for assessment.

204. The submissions on this point are accepted. MTC indicates that if CSNSW considers it appropriate to implement change, they will follow those instructions. There is therefore no requirement to make this recommendation.

OVERVIEW OF RECCOMENDATIONS

205. It is noted that the concern of the health providers in a custodial setting is the constant struggle with resourcing issues and budget constraints. However, the expert evidence in this case is very clear. Patients such as GS should be seen, and indeed must be seen within reasonable timeframes. In this case, adjustments could have been made to his medication that might have at least assisted GS in some way. It certainly may have lowered, to some extent, his psychological distress and discomfort. I have been provided with a list (being the auditing reports provided by Justice Health) that indicates he remains by no means an isolated case, and the people listed in the current document require

attention. These recommendations are being made to support the custodial health system in its efforts to address these issues.

RECOMMENDATIONS

206. I make the following recommendations:

a. **Recommendation one:** That Corrective Services NSW (**CSNSW**) and the Justice Health and Forensic Mental Health Network (**Justice Health**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at the existing correctional centre, and who are in one-out cell placement pending transfer, are to be referred to Justice Health for assessment.

b. **Recommendation two**: That Justice Health examine the Patient Administration System (**PAS**) Waiting List Priority Level Protocol and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

c. **Recommendation three:** That Justice Health consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

d. **Recommendation four:** That Justice Health consider amending the PAS Waiting List Priority Level Protocol to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the PAS Waiting List Priority Level Protocol) and who are therefore overdue for assessment.

e. **Recommendation five:** That Justice Health, considers clearly separating the current reporting of overdue patients on the “Overdue PAS report” into discrete individual clinical priority categories to allow proper analysis of the

delays experienced particularly by inmates currently delayed on the waitlist, category 3.

f. **Recommendation six**: That St Vincent's Correctional Health (**SVCH**) examine the policy titled "St Vincent's Correctional Health: Triage and Priority Waitlist" and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

g. **Recommendation seven:** That SVCH consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

h. **Recommendation eight:** That SVCH consider amending the Triage and Priority Waitlist policy to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the Triage and Priority Waitlist policy) and who are therefore overdue for assessment.

i. **Recommendation nine:** That the GEO Group Australia Pty Ltd (**GEO Group**) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at Junee Correctional Centre, and who are in one-out cell placement pending transfer, are to be referred to health staff for assessment.

ACKNOWLEDGEMENTS

207. Firstly, to the family and friends of GS, for participating in this difficult mandatory inquest, for bringing beautiful words and memories and sharing those with us so generously.

208. To the officer in charge for the preparation of the brief and gathering of relevant evidence.

209. To the representatives of the parties for assisting with presentation of various positions and submissions on relevant issues.

210. Finally to an excellent team assisting the Coroner. Ms Bird for her attention to detail, assistance with fact finding and organisation of the inquest. To Ms Coleman of Counsel for careful and mindful presentation of this case and excellent written assistance, much of which assisted me in the writing of the findings.

FINDINGS REQUIRED BY S81(1)

211. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

GS

Date of death

Between 12 and 13 September 2018

Place of death

Goulburn Correctional Centre, Goulburn, New South Wales

Cause of death

Hanging

Manner of death

Intentionally self-inflicted (in a custodial setting)

I extend my sincere condolences to the family and friends of GS for the loss of their loved one.

I now close this inquest.

Deputy State Coroner
Magistrate E Kennedy
14 July 2023