CORONERS COURT

NEW SOUTH WALES

Inquest:	Inquest into the death of RRC
Hearing dates: **Pace of hearing:**	23,24,25 May 2023 Lismore Local Court
Date of findings:	6 July 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate C Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-First Nations death in custody-adequacy of treatment and care-RIT discharge summary documentation-cell placement after a RIT-follow up after RIT-RIT model-notifying nominated cares of a serious self harm of an inmate-culturally safe and appropriate care
File number:	2021/317032
Representation:	Mr M Dalla Pozza, Counsel Assisting instructed by Ms B Lorenc, Crown Solicitor's Office Ms H Skinner, Aboriginal Legal Service representing RRC's mother

	Ms H Bennett, instructed by Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Mr J Harris, instructed by Makinson d'Apice Lawyers, representing Justice Health and Forensic Mental Health Network and Ms C McLean Mr R Reitano, instructed by McNally Jones Staff Lawyers representing Mr M Porter and Mr R Whitall
Findings:	I find that RRC died on 6 November 2021 at Shortland Correctional Centre, Cessnock, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.
Non-publication orders:	Orders for non-publication of certain evidence have been made in this inquest. The orders may be found on the Registry file.

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

IN THE NSW STATE CORONER'S COURT

LIDCOMBE

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the tragic death of RRC who was only 26 years of age at the time of his death. RRC sadly took his own life while he was in custody at Shortland Correctional Centre.

2. An inquest into the death of a person in custody is mandatory. The role of a coroner is to make the following findings that are required by s 81(1) of the *Coroners Act 2009* (The Act), namely:

   i. the identity of the deceased.
   ii. the date and place of the death; and
   iii. the manner and cause of the death.

3. In a case of this nature the community has an expectation that the death will be properly and independently investigated and that there will be a detailed account of the circumstances surrounding the death.

4. At the conclusion of the inquest the coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to prevent a similar death in the future.

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

6. RRC was of Aboriginal descent and was a Bunjalung and Yaegal man. His mother is devastated by the passing of her eldest son. He has 2 children of his own and will be forever remembered and missed by them and his other family and friends.

7. RRC's mother says her son was a good boy. He went to Yamba Public School and used to help the teacher in the Special Needs Room. RRC's mother was so proud to watch him helping the special needs students.

8. When he was 5 or 6 years old, he played little league in the Lower Clarence Junior Rugby League and was a "swifty" player with a lot of potential.

9. She says that he was a happy go lucky person who was full of laughter. He loved listening to, playing and writing music.

10. She said that at the age of ten, he found his father, who had suicided, and that it scarred RRC for life. She said that at this point his life went off the rails and he was placed into youth detention. She was proud that while he was there RRC was considered a role model for other boys and the workers liked and respected him.

11. RRC's mother's assessment of her son's character and reputation is echoed by others. He is described by the residents of Shortland Correctional Centre as the happiest guy, a good, genuine, quiet young fella, a happy bloke, outgoing, bubbly with a good sense of humour and a person who was a well regarded by the other inmates and whom everyone loved.

12. When he met his partner, it was love at first sight. They had two beautiful children, and he was the proudest father. Not being able to see and care for the children was a particular and persistent source of his distress during his incarceration.

13. RRC's mother does not feel that her son ever got the mental health treatment he required.

Custody

14. On 10 September 2021 RRC was taken into custody. Upon arrest, RRC told police that he "didn't want to live anymore" and he asked police to shoot him. His mother explained that during that period he was experiencing distress as an ADVO prevented him from seeing his children.

15. Police took him to James Fletcher/Mater Mental Health Service for a mental health assessment. The psychiatrist assessed RRC as not being acutely suicidal and that there was no evidence of a pervasive affective or psychotic illness. She diagnosed complex Post Traumatic Stress Disorder and substance abuse disorder and prepared a long-term discharge plan which included long term psychotherapy for management of affective instability and distress tolerance.[1]

16. Following the mental health assessment, RRC was taken by police to Newcastle Court where he was refused bail.

Shortland Correctional Centre

17. On 15 September 2021, RRC was received into custody at Shortland Correctional Centre. A Health Problem Notification form ("HPNF") was prepared. The HPNF provided that RRC would be placed in a cell together with another person, "until screened". Being placed in a two out cell is a measure that is commonly directed in circumstances where an inmate is assessed at being at a risk of self-harm. That HPNF does not disclose that RRC expressed any

[1] Ex 1 Vol 2, Tab 40, Case Management File, p. 75.

suicidal intent, it appears that the reason for this instruction was because RRC had told police on 10 September 2021 that he did not want to live anymore.

18. On 17 September 2021, RRC underwent a Reception Screening Assessment "RSA". A further HPNF was prepared on that same date. This instructed Corrective Services officers to monitor RRC for isolative or withdrawn behaviour, mood swings, agitation, "change in level of risk from others" and "inappropriate talking or laughing". In contrast to the HPNF two days earlier, the new HPNF recommended "normal cell placement".[2]

Interactions with Justice Health

Justice Health Nurse Review on 15 October 2021

19. On 15 October 2021, RRC presented to the Justice Health clinic with an injury to his knuckle which occurred when he punched a pole while working out. The nurse asked RRC whether he had punched the pole deliberately and he told her that it was an accident.[3] In her statement the nurse said that, during the review, RRC was cheerful and denied any attempt to self-harm.[4] Even so, the nurse instructed Correctional Officers, through an HPNF, to "watch for isolative or withdrawn behaviour, mood swings, agitation, change in level of risk from others, inappropriate talking or laughing". She says that she highlighted these symptoms as "a precautionary measure" based on her review of the clinical records as opposed to in relation to anything she specifically observed on 15 October 2021. She says that RRC had not displayed any of these symptoms during her interview with him.[5]

Justice Health Nurse Review on 17 October 2021

[2] Exh 1 Vol 5, Tab 65B, Statement of MP, [13]; MP-3.
[3] Exh 1, Vol 3, Tab 52B, Statement of BM, [12].
[4] Ibid.
[5] Ibid, [18].

20. On 17 October 2021, RRC cut his elbow pit with a razor blade. He told Correctional Officers that he wanted to die. This prompted a further nursing review. RRC was seen by the same nurse who saw him on 15 October 2021, and he told her that he had cut his arm with a razor because "the voices told him to do it". He denied hearing voices at the time of the review and reported having no further thoughts of self-harm. [6] The nurse prepared a further HPNF. That recorded that RRC reported that he wanted to die.

21. He was placed into the Health Centre assessment cell with continuous observation by CCTV and the nurse formulated the following plan:

    a. RRC was to have "minimal prison greens", safe cell blankets and no access to sharps or razors[7]; and
    b. RRC would be reviewed the next day.

22. On 18 October 2021 RRC was reviewed by a RIT panel. A RIT panel is a three-person multidisciplinary panel convened to develop a management plan in relation to an inmate who is at risk of suicide or self-harm[8].

23. The Panel was convened by a Correctives Officer who held the position of RIT Coordinator, a Service and Programs Officer ("SAPO")) and a mental health nurse from Justice Health.

24. The Correctives Officer says that RRC told the RIT Panel that the reason why he self-harmed was because he couldn't see his children.[9] He also said that he felt depressed when he was unable to speak with his children and happy when he could speak with them.[10] RRC also told the panel that he had good family support and that the action was an impulsive one because he felt very stressed at that time. He denied ongoing suicidal ideation.[11]

[6] Exh 1, Vol 3, Tab 52A, Statement of AW, [12].
[7] Exh 1, Vol 3, Tab 52A, Statement of AW, [14(a).
[8] Exh 1 Vol 5, Tab 65B, Statement of MP, [6].
[9] Ibid, [16].
[10] Exh 1, Vol 3, Tab 52C, Statement of CM, [18(d)].
[11] Ibid, [20].

25. The Panel decided to keep RRC in the assessment cell overnight. They also decided to refer RRC to a psychologist and to an Aboriginal SAPO.

Assessment by psychologist on 19 October 2021

26. In her statement the psychologist said that RRC initially presented with a low mood, but says that after rapport was built, he appeared euthymic.[12] He denied a history of suicidal behaviour in the community. She says that RRC described engaging in the self-harming behaviour due to feeling stressed about not having contact with his children.[13] RRC appeared to the nurse to be future focussed and described plans to be involved in his children's lives.[14] He requested to be discharged from the RIT and returned to the pod where he had multiple supports and received external support from his mother.[15] The nurse concluded that RRC had nil evidence of imminent risk of self-harm and noted that it appeared to her that discharge from RIT appeared appropriate at that time.[16]

Assessment by Aboriginal SAPO on 19 October 2021

27. The Aboriginal SAPO saw RRC on 19 October 2021.[17] He says that RRC told him that he had a cousin in the pod who was a support to him and that he wanted to go back to his cell to be with him.[18] He gave RRC some books that he had requested and stated that there was nothing in RRC's behaviour that alarmed him.[19]

The RIT review 19 October 2021

[12] Exh 1, Vol 5, Tab 65E, Statement of TJ, [8].
[13]Ibid, [9].
[14] Ibid, [11].
[15] Ibid, [12].
[16] Ibid, [13].
[17] Exh 1, Vol 5, Tab 65D, Statement of TD, [5].
[18] Ibid, [4].
[19] Ibid, [12].

28. On 19 October 2021 a decision was made by the RIT panel to discharge RRC from the RIT management plan. The RIT Discharge Plan was signed by RRC and all the members of the RIT team.

29. Each of the RIT panel members have a different understanding of whether any conditions or referrals were made in relation to RRC's discharge and, if so, what those conditions/referrals were.

30. On RRC's RIT discharge plan document 'Part A' was completed and a box was ticked that said, "Management plan with no further actions (complete A and D)".[20] Part A and Part D were then duly completed. Part A recorded the action that was taken by the RIT panel and the likely triggers for future risk. Part A does not record any future planning in relation to RRC.

31. The part of the document that records future planning by the RIT panel is 'Part B'. That provides for cell placement conditions and other conditions/referrals. 'Part B' on the form is headed "management Plan with the conditions/referrals requiring follow-up by the RIT coordinator". Part B was not used.[21]

32. Even though the discharge form made no attempt to record any condition or referral or cell placement decision upon discharge to the RIT, the panel members say that there were.

33. The RIT panel coordinator gave a statement that the panel decided that RRC would be discharged into a two-out cell with another inmate sharing his cell.[22] This is also known as normal cell placement or, being on a "green card." His own handwritten notes of the RIT meeting and his notes in OIMS both refer to a two-out cell placement for RRC. He says that in accordance with his usual practice, he spoke to someone on the wing where RRC was to be accommodated and told that person that RRC would be returning back to the wing on a "green card" and that he was to be placed with another Aboriginal inmate, possibly in the same pod as his cousin.

[20] Exh 1 Vol 5, Tab 65B, Statement of MP, MP-5.
[21] Ibid.
[22] Exh 1 Vol 5, Tab 65B, Statement of MP, [25].

34. The SAPO on the RIT panel says that the RIT panel unanimously agreed that RRC would return to the pods and be placed in a two-out cell. [23] He says that this would amount to a "protective measure" for RRC and that it would be unusual for an inmate to move immediately from RIT to one-out placement.[24]

35. The Justice Health nurse on the RIT panel said that she didn't remember there being any decision made for cell placement for RRC. She prepared the HPNF. The HPNF is the document that informs the Corrective Service Officers of what they "must immediately implement" when a person is returned into Corrective's care from Justice Health unless there are overriding considerations.[25] The nurse wrote in the HPNF that the RIT was suspended, and that RRC should go into "normal cell placement" with normal property.[26] She did not understand there were to be any restrictions to his cell placement.

RRC's accommodation after his discharge from the RIT

36. On 19 October 2021, RRC was moved back to the pod and into cell on his own. Another inmate moved in the following day.[27]

37. On 24 October 2021, RRC was moved into a cell which he shared with his cousin.[28]

38. On 30 October 2021, RRC moved into a single cell.[29] His cousin says that RRC proposed to him that they request that they both be placed in a one out cell because some were available.[30] His cousin feels that in hindsight, he believes that RRC ought to have stayed in the two-out cell.[31]

[23] Exh 1 Vol 5, Tab 65C, Statement of RW, [17].
[24] Ibid, [18].
[25] CSNSW COPP 6.1.
[26] Exh 1, Vol 3, Tab 52C, Statement of CM, [25].
[27] Exh 1 Vol 2, Tab 43A, Cell placement chronology for RRC.
[28] Ibid.
[29] Exh 1 Vol 2, Tab 42E, Housing Location History.
[30] Exh 1 Vol 1, Tab 25, Statement of JH, [8]; Interview with JH, 1.59.
[31] Exh 1 Vol 1, Tab 25, Statement of JH, [8].

39. RRC's mother says that the placement in a single cell had ramifications for her son's mental health.[32] In addition, it meant that there was no-one in the cell who could have intervened or alerted authorities of the events which ended RRC's life.

Justice Health after the RIT discharge

40. RRC continued to be seen by the Justice Health Nurse after his discharge from the RIT. She continued to give treatment to his wound.[33] She says that when she saw him on 23 October 2021 that RRC told her that he had no intention to kill himself and his self-harming episode on 17 October was to get "sleepers" (presumably, sleeping tablets) and to get attention.[34] She says that she had a long conversation with RRC about his mental health and the self-harm attempt and advised him either to notify a correctional officer or to utilise the "knock up system" to request to speak to a nurse immediately should he experience any further thoughts of self-harm.[35]

41. When she saw RRC again on the following day, she noted that he was "his normal jovial self."[36]

42. The nurses' perceptions of RRC were shared by his cousin, who stated that during the period after the RIT that RRC seemed happy and settled; they would train together and laugh every day and would talk positively about the future. He said:

> "RRC was the man with the biggest smile on his face, but clearly it was masking his great sadness. I say this on reflection. I had no idea that he was

[32] Exh 1 Vol 1, Tab 12, Transcript of Electronic Statement of RRC's mother page 16.
[33] Exh 1, Vol 3, Tab 52B, Statement of BM, [30].
[34] Ibid, [34].
[35] Ibid, [35].
[36] Ibid, [42].

suffering emotionally. RRC, I guess like a lot of young Aboriginal men, can mask their true feelings."[37]

43. On 1 November 2021, RRC was again assessed by the psychologist. She reported him to be future focused towards re-establishing contact with his children and documented nil concerns related to his behaviour or well-being since he had returned to the wing after his discharge from the RIT.[38] She did not make an assessment as to appropriate cell placement.

44. The cell in which RRC was accommodated at the time of his death was equipped with ordinary bed linen; rather than a safety blanket.[39] The cell was furnished with bunk beds,[40] the frames of which, as borne out by subsequent events, provided an anchor point for a noose to be fixed. The installation of the bunk beds occurred during 2016 when there was a critical shortage of prison beds. Since RRC's death these beds have been removed.

Independent Expert Psychiatric Review

Dr Olav Nielssen

45. Dr Olav Nielssen, Clinical Professor of Psychiatry, Faculty of Medicine and Health, University of Sydney reviewed the coronial brief which included all the custodial and medical records.

46. Dr Nielssen noted that RRC had been diagnosed with various psychiatric disorders. Dr Nielssen noted that the circumstances of RRC's arrest raised a possibility that he had an underlying depressive or even psychotic illness but noted that the observations made by clinical staff and other inmates did not reveal outward signs of distress.

[37] Exh 1 Vol 1, Tab 25, Statement of JH, [9].
[38] Exh 1 Vol 2, Tab 36D, Memorandum Report by TJ to Mick Dudley, Governor; Exh 1, Vol 5, Tab 65E, Statement of TJ, [17].
[39] Exh 1 Vol 5, Tab 65A, Statement of Wayne Taylor, [4(a)].
[40] Ibid, [4(e), (f) and (g)].

47. Accordingly, Dr Nielssen is of the opinion that the care RRC received in custody: "was generally appropriate, based on his reported presentation and treatment needs and the level of contact with prison health staff in the two months before his death".

48. Dr Nielssen pointed out that the absence of a complete psychiatric history, informed by a review of all available records as a potential shortcoming; however, he is not convinced that such an assessment would have prevented RRC's death because he is of the opinion that RRC's decision to commit suicide was made on impulse and without any recent outward indicators of acute distress or active mental illness.[41]

49. Dr Nielssen says that "in retrospect" the HPNF form allowing RRC to return to normal cell placement after the RIT was a mistake. He is particularly critical of the absence of any detailed risk management discharge plan of a type perhaps contemplated by the policy. He stated that "the main shortcoming would appear to be in not stipulating the nature of subsequent reviews, including if indicated, a further review by the prison mental health team."[42]

Associate Professor Longbottom

50. The Court also had the assistance of an independent report prepared by Associate Professor Marlene Longbottom of the Indigenous Education and Research Centre at James Cook University. Associate Professor Longbottom holds a PHD and has conducted Postdoctoral research programs with a focus on working with Indigenous communities. Professor Longbottom brings an important perspective to this inquest, being a person of the Jerrinja Aboriginal community and a Yuin woman.

51. Associate Professor Longbottom notes that aboriginal people are family orientated with strong connections to family and friends. She notes that RRC struggled with his

[41] Exh 1 Vol 5, Tab 73, Report of Dr Olav Nielssen, page 8.
[42] Ibid, page 9.

disconnection from his family and friends[43]. She especially notes the difficulties with RRC being housed in a correctional centre that was Off Country.[44]

52. Importantly, Associate Professor Longbottom also acknowledged and referred to the effective of cumulative and multigenerational trauma experienced by Indigenous persons and, more specifically to RRC's case the trauma he had suffered through his experiencing and witnessing adverse experiences as a child (including the passing of his father and extended family members).[45]

53. Associate Professor Longbottom opines that there were "extensive gaps in service provision" to RRC[46] and that the care RRC received was "reactive" and "episodic" rather than "preventative" and "holistic".[47] Most relevantly, she said that the absence of attempts to engage RRC on the distress he had reported experiencing due to his inability to see his children and a lack of follow up after discharge from the RIT.[48]

54. Associate Professor Longbottom suggests that the services RRC received were lacking in cultural competence[49] and was not "culturally safe".[50] The Western assessment tools used did not factor the cultural needs of Aboriginal and Torres Strait Islander people, thus missing many cultural nuances. Professor Longbottom draws particular attention to the fact that, in her opinion, the services provided to RRC were neither culturally not trauma informed.[51]

55. A further particular matter, referred to by Associate Professor Longbottom in the course of her discussion of the gaps in service and lack of cultural competence is the power inequities between RRC and those responsible for providing him care. She says that it appears that

[43] Exh 1 Vol 5, Tab 74, Report of Professor Marlene Longbottom, page 8.
[44] Ibid, page 8.
[45] Ibid, page 9.
[46] Ibid, page 9.
[47] Ibid, page 10.
[48] Ibid, page 17.
[49] Ibid, page 12
[50] Ibid, page 23.
[51] Ibid, page 20.

RRC felt that he could not speak openly with staff.[52] She considers that this is the likely explanation for RRC not using the cell "knock up" system.[53]

56. Associate Professor Longbottom observes that the inclusion of Aboriginal workers is vital to the provision of a culturally safe and comprehensive working environment.[54]

57. Associate Professor Longbottom expresses the following opinion:

> "Aboriginal deaths in custody continue to the current day as a result of the inadequate health care provided to Indigenous people while in prison." [55]

58. Associate Professor Longbottom makes a number of recommendations. Of particular relevance for present purposes are her recommendations:

    a. Employing an Aboriginal Health Worker at each institutional clinic and in custodial and forensic settings;
    b. Genuine engagement with the NSW Aboriginal Health and Medical Research Council and member services; and,
    c. A review of the current model of care.[56]

Dr Sullivan, Consultant Forensic and Adult Psychiatrist

59. Dr Danny Sullivan prepared a report on behalf of Justice Health. There is much common ground between Dr Nielssen and Dr Sullivan. Dr Sullivan (like Dr Nielssen) found no clear diagnosis of major mental illness or any disorder resulting in "sustained impairment of functioning or distress"[57]. Dr Sullivan agrees that the main factor associated with RRC's apparent suicide was his placement in a single cell. He also agrees that this was a considered

[52] Ibid, page 13.
[53] Ibid, page 14.
[54] Ibid, page 15.
[55] Ibid, page 23.
[56] Ibid, pages 26 – 27.
[57] Exh 1 Vol 5, Tab 75, Report of Dr Danny Sullivan, [87].

decision made having regard to RRC's mental state.[58] He considered that RRC received appropriate treatment and care from Justice Health.[59]

Mr Creighton, Acting Director of Aboriginal Strategy and Culture, Justice Health

60. The Court also has the very considerable benefit of a statement by Mr Creighton.

61. Mr Creighton is a Gomeroi man from the Aboriginal Community of Moree. He has connections to the Bundjalung nation, as he moved to Widjabul Wia-Bal Country in his early teenage years.[60]

62. Mr Creighton agrees with Associate Professor Longbottom as to the negative effects for RRC of being Off Country. He says that the anxiety from being Off Country can be "overwhelming" if there is "Sorry Business" taking place whilst an inmate is Off Country. He adds, however, that Justice Health does not control the location of patients within NSW Correctional Centres.[61]

63. Responding to Associate Professor Longbottom's observations as to a lack of cultural mentors available to RRC, Mr Creighton says that Cultural mentors are provided through the Aboriginal Services and Programs officers employed at Corrective Services NSW.[62]

64. Mr Creighton agrees that Aboriginal patients face barriers to accessing culturally competent care. He suggests that a strategy to combat this would be to expand the Aboriginal workforce (at Justice Health) generally.[63] Mr Creighton explains that there are particular difficulties to attracting persons of Indigenous Heritage to work in a correctional context.

[58] Ibid, [89].
[59] Ibid, [90].
[60] Exh 1, Vol 3, Tab 52E, Statement of Grantley Creighton, [2].
[61] Ibid, [10].
[62] Ibid, [11].
[63] Ibid, [13].

65. Mr Creighton disagrees with Associate Professor Longbottom's conclusion that RRC died as a result of inadequate health care. He notes that the rate of death of indigenous persons in custody is not proportionally higher (and, in fact, is lower than the rate of deaths of non-indigenous inmates). That is not to say that the rate of the incarceration of Indigenous persons is not high and, in this regard, Mr Creighton notes an absence of diversion programs to prevent Aboriginal people entering custody[64]; in other words, Mr Creighton sees the high rates of incarceration of persons in custody as the real issue.

66. In relation to Associate Professor Longbottom's recommendation that an Aboriginal Health Worker be employed at each institutional clinic and in custodial and forensic settings, Mr Creighton describes how Justice Health has obtained funding to secure seven full-time Aboriginal Health Worker positions across the State; though he says that, despite best efforts, only 4 of these positions are presently filled.[65] The role of an Aboriginal Health Worker is to act as an advocate for Aboriginal people and their families, to assist in case management and the coordination of service provision, to provide assistance and care to Aboriginal patients and facilitate the relationship between Aboriginal patients and health professionals and to provide culturally appropriate health education to Aboriginal patients, staff and other stake holders.

67. In terms of Associate Professor Longbottom's recommendation as to engagement with the NSW Aboriginal Health and Medical Research Council, Mr Creighton says that Justice Health is currently engaged in such meetings.[66]

68. In relation to Associate Professor Longbottom's recommendation as to a review of the current model of care, Mr Creighton says that:

[64] Ibid, [15].
[65] Ibid, [27].
[66] Ibid, [18(b)].

a. Every police, project or initiative introduced by Justice Health must have an Aboriginal Health Impact Statement; and

b. At a broader level, the development of culturally safe services for Aboriginal patients is guided by its Statement of Commitment to Aboriginal Health and 10 year Strategic Plan.

69. More broadly, Mr Creighton describes how NSW Justice Health:

a. Has an Aboriginal Mental Health program (of which funding is available to two trainees for Justice Health, one at the Forensic Hospital and the other at the Custodial Mental Health team)[67];

b. Has Cultural Competency Training for Justice Health Staff;[68]

c. Has the following strategies to improve Aboriginal Health and Workforce including the following:

i. The Aboriginal Chronic Care Program[69];

ii. Engagement with the Aboriginal Community Controlled Sector[70] (examples listed are the Winnunga Nimmityjah Aboriginal Health Service (following a recommendation made by Deputy State Coroner Ryan[71]); Waminda South Coast Women's Health and Welfare Aboriginal Corporation[72]; Durri Aboriginal Corporation Medical Service based on the mid North Coast[73]; the Wellington Aboriginal Corporation Health Service,[74] the MRRC Pilot Program[75]; and the Kinchella Boys Home Aboriginal Corporation.[76]

[67] Ibid, [39].
[68] Ibid, [34] – [37].
[69] Ibid, [40].
[70] Ibid, [42].
[71] Ibid, [48].
[72] Ibid, [53].
[73] Ibid, [56].
[74] Ibid, [60].
[75]Ibid, [64].
[76] Ibid, [67].

70. Of these, the work with the Durri Aboriginal Corporation Medical Service is of most interest as it appears to be the only initiative that covers the geographical area of Shortland Correctional Centre.

71. Mr Creighton also describes the efforts made to arrange for access to Medicare for Aboriginal people in custody (arising out of recommendations made into the death of Mr Mootijah Shillingsworth)[77]. This is not a matter which relates to the circumstances of RRC's death.

Issues

72. An issues list was prepared prior to the inquest commencing to provide structure to the hearing. Some of the issues are no longer of great relevance and other issues have emerged during the inquest. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

Was the 19 October 2021 RIT discharge plan document completed appropriately?

73. The discharge plan document that was prepared following the 19 October 2021 RIT Panel was not appropriate. The Part of the form that was selected and completed was Part A "management plan with no further actions". This does not correlate with the notes the RIT coordinator made in OIMS.

74. Mr Taylor, General Manager, Statewide Operations, Custodial Corrections CSNSW on behalf of Corrective Services, informed this court that Part B of the discharge form ought to have been selected and completed. Part B of the form sets out conditions/referrals for the inmate upon their discharge from the RIT including any cell placement condition.

[77] Ibid, [70].

75. The failure to record the cell placement decision on the discharge plan meant that there was a lack of clarity as to the decision of the RIT panel for RRC's future cell placement.

76. While a plan was recorded elsewhere ie. on the OIMS notes to which Corrective Services staff had access to, this was not a substitute for recording these matters on the discharge plan. Mr Taylor explained that case notes would only be read where there was "reasonable cause to do so". I accept his evidence, that in a normal case, a corrective officer inquiring as to the terms of a decision of a RIT Panel would look at both the HPNF and discharge plan.

77. There were additional deficiencies in the discharge plan documentation. Under the section dealing with "likely triggers for future risk" the following is recorded: "contact with children may upset". It is clear from the evidence that RRC's children were a protective factor for him. It is clear, from the case notes, that the panel appreciated this. It is likely that what was intended to be conveyed in this part of the discharge plan was RRC's distress at being unable to see his children. However, the opposite sense can be conveyed by the words written on the discharge plan. This had the potential to create some confusion as to what the RIT Panel had actually observed. Also, the discharge plan was not disseminated in accordance with policy to the Officer in Charge of the accommodation unit RRC was discharged to, nor onto his medical file.

78. The Commissioner for Corrective Services accepts that this evidence raises real concerns as to documentation, dissemination and compliance with Corrective Services policies and procedures. The Commissioner accepts that the failures were of a systemic nature.

79. Since RRC's death Corrective Services have completed a review and update of the relevant policy. Mr Taylor stated that amendments have been made requiring a decision for cell placement to be made on the discharge plan for every inmate that is discharged from a RIT. Reasons for the decision are also required.

80. Version 1.6 of Correctional Officers Policies and Procedures (COPP 3.7) was introduced on 23 May 2023 and contains the changes to the process of discharging an inmate from a RIT.

81. There is a requirement now, that a RIT management panel provide a response for every question of the Part 3: Risk Intervention Team Management Plan. The practical effect of the new version of COPP 3.7 is that a cell placement decision is now mandated.

82. Accompanying these changes are more detailed forms which provide expanded criteria for consideration and documentation of reasons for a RIT panel's determination regarding cell placement.

83. Given the review and subsequent amendments to the relevant policy since RRC's death I do not propose to make any recommendation in relation to the RIT discharge plan.

What plan was made for RRC's cell placement on 19 October 2021?

84. The lack of detail in the discharge plan document has the further consequence that there is uncertainty as to the terms of the panel's discharge decision. This uncertainty arises in relation to both the future accommodation decision and whether the panel made any conditions or recommendations for follow up upon RRC's discharge.

85. The RIT Co-ordinator and the SAPO both intended that RRC would be accommodated in a two-out cell following his discharge. The following evidence supports that finding:

    a. The contemporaneous records made by the co-ordinator and the entry he made in the OIMS system on 19 October 2021. Both these documents refer to accommodation being "2 out".
    b. The evidence of the SAPO that it was the usual practice at Shortland Correctional Centre that an inmate who had been discharged from a RIT would be accommodated 2 out. He stated that the only exception to accommodating an

inmate in a 1 out cell post RIT discharge would be where non-association or other conditions may make it inappropriate for that inmate to share a cell.

86. The other member of the RIT panel, the nurse, had a different understanding of what the panel had decided regarding RRC's post-discharge accommodation. She completed the HPNF and recorded that "normal cell placement" was appropriate.

87. The nurse says that she does not recall any discussions about cell placement between the members of the 19 October RIT panel. She had no contemporaneous notes and a limited recollection.

88. The nurse felt that, had there been a decision regarding two out cell placement at the RIT, she would have recorded this on the HPNF. She said that it is possible that there was a discussion of that issue when she was not present.

89. I am satisfied on the balance of probabilities that the most likely explanation for the divergence in the evidence of the members of the RIT panel is probably due to a misunderstanding. I accept the evidence that the practice at Shortland was that accommodation post-RIT would be two out, and there may have been a degree of assumed knowledge. The nurse was from an external agency. She had comparatively limited experience sitting on a RIT as of 19 October 2021. She may have misunderstood references to "normal practice", intended by the Corrective Services members of the RIT to signify the placement of RRC two-out as a reference to "normal cell placement".

90. The misunderstanding serves to illustrate the importance of clear documentation of the discharge plan.

Were there any conditions or recommendations made upon discharge from the RIT on 19 October 2021?

91. None of the contemporaneous documents; the discharge plan, the HPNF, the OIMS notes and the handwritten notes, refer to any conditions at all being made.

92. It is clear, however, that follow up by psychology services and contact with the Aboriginal liaison service occurred back in the wing.

93. Whether these were conditions upon discharge or recommendations is unclear.

94. Once again this serves to illustrate the importance of clear documentation of the discharge plan.

Why was RRC in a one out cell?

95. On the night of his discharge, RRC was placed into a one- out cell: contrary to the usual practice at Shortland Correctional Centre. It appears that this occurred because the HPNF recommended "normal cell placement".

96. There is no dispute on the evidence that it was inappropriate for RRC not to have been accommodated in a two-out cell immediately after his discharge.

97. He was in a one out cell for one night and was then placed in a two-out cell (including with his cousin) until 30 October 2021. On that day, at his and his cousin's request, he was placed in a one out cell where he was accommodated until the date of his death. He was discharged from the RIT on 19 October 2021 and approximately three weeks later he took his own life.

98. The policy in force at the time of RRC's death, in particular, Pt. 2.4 of COPP 5.2 (the Corrective Services NSW Policy document concerning Inmate accommodation) provided that a two out cell placement is suitable for inmates with a significant risk factor(s) that indicates that they must share another cell with a compatible inmate.

99. Aboriginality is identified as a "significant risk factor" for the purposes of cell placement. (Mr Taylor explained that the rationale for this is that it is thought desirable for Aboriginal inmates to receive support from inmates with similar cultural identities.) Self -harm was also considered a "significant risk factor."

100. The presence of the two "significant risk factors" would suggest that RRC ought to have been accommodated in 2 out cell accommodation.

101. Dr Nielssen said that he would ordinarily expect an inmate to be in a two-out cell for a period of either 2-4 weeks or one month, upon discharge from a RIT. He said that a "cautious" policy should be adopted before cell placement in a one out cell.

102. Dr Sullivan did not feel able to impose an "arbitrary" time frame before an inmate discharged from a RIT could be accommodated in a one- out cell; however, he opines that a clinical assessment should take place before this occurs.

103. I accept the expert evidence that a further assessment and decision on cell placement ought to have occurred before RRC was permitted to be accommodated in a one-out cell on 30 October 2021. RRC was at risk of an impulsive act of self-harm. He required care and support to address the risk of impulsive suicide. This is sadly demonstrated by the events which caused him to end his life. He should have been discharged from the RIT with conditions requiring this, set out in a discharge plan.

104. Both Dr Nielssen and Dr Sullivan agree that a step-down model including an assessment and cell placement decision following discharge from a RIT would be beneficial.

105. Mr Taylor also agrees that a person discharged from a RIT would benefit from future support. He says that, following discharge from a RIT, there may be a need for "down-river" supports and referrals.

106. Corrective Services policies in existence at the time of RRC's death (COPP 3.7 (dealing with the management of inmates at risk of self-harm or suicide) provides (at part 6) for the management of an inmate pursuant to a "management plan". A "management plan" is described (at 6.1) as a plan dealing with, amongst other things, "cell placement options", "diversionary activities" and "referrals".

107. Similarly, cl. 7.2 of COPP 3.7 (dealing with discharge plans from a RIT) suggests that services may continue to be provided to a person discharged from a RIT even after his or her discharge. That clause provides:

"The RIT may discharge the inmate:

- to a specialist unit
- with conditions and/or referrals
- with no further actions"

108. Clause 7.4 (which deals more specifically with discharge with conditions and/or referrals) states:

"Even when the RIT assesses no current risk of suicide or self-harm, some inmates who are discharged from a RIT Management Plan will require ongoing management strategies and coordinated provision and review of services and programs to minimise their longer-term risk of suicide or self-harm. For example, inmates who have complex needs will likely require ongoing coordinated management by CSNSW and JH&FMHN beyond the RIT process.

The RIT Discharge Plan should give recommendations to supplement normal management processes with specific conditions around referred services to be provided.

The RIT Discharge Plan must ensure that the risk factors that precipitated the RIT are addressed through appropriate referrals to CSNSW services and programs and JH&FMHN. Any services from the RIT Management Plan that require ongoing contact with the inmate should be recorded in the RIT Discharge Plan. Any new referrals to services or programs should also be recorded in the RIT Discharge Plan."

109. In the course of her evidence, the RIT nurse referred to her experience working in Western Australia. A model there involved a step-down period following a discharge from a RIT for a period of 1 month.

110. At Shortland Correctional Centre, the RIT process does not further support an inmate. Rather, the RIT process is primarily concerned with an acute situation and involves keeping an inmate under observation or in an assessment cell. Mr Taylor explained that, in practice, a RIT tends not to consider the broader matters contemplated in the sections of COPP 3.7 dealing with RIT management and discharge plans. He says that a RIT is focussed on dealing with an immediate threat of suicide and involves placing the inmate in a "safe environment", usually an assessment cell with CCTV cameras, lights and safety blankets. Mr Taylor agreed that there was value in considering a "step down" process with associated follow up with the inmate.

111. The RIT process could clearly be enhanced. Firstly, to obviate the concern that an inmate may be motivated to get off the RIT as quickly as possible just to get out of an observation cell. He or she may be reluctant to provide information which would be thought to be harmful to his or her prospects of getting off the RIT.

112. Furthermore, the RIT panel could consider a more complete history of the inmate. The 19 October 2021 RIT panel were not aware of the fact that RRC was in custody after he had asked police to shoot him and had said that he wanted to die. The SAPO on the panel said that he was unaware of the possible self-harm incident two days earlier on 17 October 2021.

113. Dr Sullivan referred to a model in Victoria known as the "Hope Inside" program. The essential features of that program are:

a. It is a 12-week program;
b. It begins with a clinician meeting, at which an inmate is assessed;
c. That clinician arranges for other persons and services to assist based on the inmate's initial presentation;
d. It involves a list of contacts being prepared whom an inmate can contact in the event that he or she is feeling low;
e. It involves options for safety planning that could continue in prison.

114. The Court is not aware of further details of the HOPE Inside Program. Dr Sullivan's description of the model might provide a starting point for exploration of a model, alternative to the RIT process, to provide support to inmates at risk of committing acts of self-harm (including a risk of impulsive acts of self-harm).

115. Corrective Services New South Wales acknowledges the continual need to review the RIT process and have commenced discussions with Justice Health on issues of continuity of care relating to RIT plans. In that regard I propose to recommend that:

1. That Corrective Services NSW review the process of discharge from a RIT; with a view to considering whether the current process is effective in reducing the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT;

2. That, in the course of conducting its review referred to in recommendation 1, Corrective Services have regard to the RIT model in Western Australia;

3. That, in the course of conducting its review referred to in recommendation 1, Corrective Services New South Wales consider notifying nominated carers of a RIT placement or suicide attempt;

4. *That Corrective Services NSW consider whether alternative models to the RIT process could be utilised to reduce the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT;*

5. *That, in the course of conducting its consideration referred to in recommendation 4, Corrective Services have regard to the HOPE Inside model in Victoria;*

6. *That, in the course of conducting the review referred to in recommendation 1 and giving the consideration referred to in recommendation 4, Corrective Services NSW consider the importance of:*

   i. Providing for continuity of care; and

   ii. Providing for a support person to be nominated

Culturally safe and appropriate care

116. I accept Associate Professor Longbottom's opinion that there are great benefits of providing culturally appropriate and informed care to Aboriginal inmates.

117. Associate Professor Longbottom explained that culturally informed and appropriate care to Aboriginal inmates would include:

   a. Providing greater access to Aboriginal staff and particularly to Aboriginal mentors;

   b. Providing a model of care which is proactive, rather than reactive;

   c. Providing a model of care which encouraged RRC to confide openly with those responsible for providing him care;

d. Providing a model of care which addresses the power inequities that exist in a custodial context; and

e. Providing a model of care which provides for continuity of care.

118. The step-down RIT model, along the lines of the Western Australia model, might accommodate a greater opportunity for the above. It might enable or encourage a greater relationship of trust to be developed.

119. The longer-term clinical care suggested by Dr Nielssen and Dr Sullivan could provide an opportunity for the measures suggested by Associate Professor Longbottom to be provided. I recommend that Corrective Services, in conducting a review of the RIT model, consider the importance of providing culturally safe and appropriate care and, in particular, consider how support can be provided to an Aboriginal inmate by an Aboriginal identified support person or mentor.

120. Mr Taylor informed the court of the following cultural programs that have been implemented:

a. Cultural camp, where Aboriginal inmates work with Local Aboriginal Land Councils,

b. Yarning Circles have been built in correctional centres for programs and events. Since RRC's death there have been three yarning circles built at Shortland Correctional Centre. They have also been constructed in 8 other correctional centres since 2021 and there are 8 additional sites being built.

c. State-wide cultural strengthening programs, are implemented to strengthen the foundations of Aboriginal people's knowledge of their culture and values

121. Corrective Services New South Wales acknowledged there is more to be done in relation to increasing culturally appropriate care to Aboriginal inmates and is committed to continually improving Aboriginal inmates' circumstances.

122. In that regard I recommend that in conducting the review of the RIT process that Corrective Services New South Wales consider the importance of providing culturally safe and appropriate care to Aboriginal inmates by an Aboriginal support person or mentor. (the challenge in recruiting is noted).

123. Associate Professor Longbottom was of the opinion that the Aboriginal Medical Research Council could provide beneficial input. Mr Creighton, from Justice Health, explained that Justice Health already engage with the Aboriginal Medical Research Council. I recommend that Corrective Services New South Wales in conducting the review of the RIT process, consult the Aboriginal Medical Research Council for advice.

Conclusion

124. RRC was discharged from a RIT without a fully documented discharge plan with conditions relating to his future care and cell placement. His mother was not informed of his serious attempt at self-harm in custody and the fact that he had been placed on a RIT. She was deeply involved in RRC's life and would have loved to have had the opportunity to provide extra support to him at that time. In hindsight, more could have been done to put in place protective measures for RRC when he was returned to the wing and to continue his care and treatment.

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

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

Findings:

I find that RRC died on 6 November 2021 at Shortland Correctional Centre, NSW from hanging. His death was intentionally self-inflicted while he was in the lawful custody of Corrective Services NSW.

Recommendations:

To the Chief Executive Officer, Corrective Services New South Wales:

1. That Corrective Services NSW review the process of discharge from a RIT; with a view to considering whether the current process is effective in reducing the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT;

2. That, in the course of conducting its review referred to in recommendation 1, Corrective Services have regard to the RIT model in Western Australia;

3. That, in the course of conducting its review referred to in recommendation 1, Corrective Services New South Wales consider notifying nominated carers of a RIT placement or suicide attempt;

4. That Corrective Services NSW consider whether alternative models to the RIT process could be utilised to reduce the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT;

5. That, in the course of conducting its consideration referred to in recommendation 4, Corrective Services have regard to the HOPE Inside model in Victoria;

6. That, in the course of conducting the review referred to in recommendation 1 and giving the consideration referred to in recommendation 4, Corrective Services NSW consider the importance of:

   i. Providing for continuity of care; and
   ii. Providing for a support person to be nominated

7. That Corrective Services, in conducting the review referred to in recommendation 1 and giving the consideration referred to in recommendation 4, consult the Aboriginal Medical Research Council for advice.

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