CORONER'S COURT

OF NEW SOUTH WALES

Inquest: Inquest into the death of TH

Hearing dates: 5 December 2023

Date of findings: 12 December 2023

Place of findings: Coroner's Court of New South Wales

Findings of: Magistrate David O'Neil, Deputy State Coroner

Catchwords: CORONIAL LAW – death in custody, self-inflicted

File number: 2022/153319

Representation: Mr Winter-Mirenzi Coronial Advocate
Ms Holmes for the Commissioner for Corrective Services NSW
Ms Szulgit for the Justice Health and Forensic Mental Health Network.

Findings:

Identity:	The person who died is TH
Date:	TH died on 26 May 2022
Place:	TH died in his cell in, South Coast Correctional Centre NSW
Cause:	Chronic Coronary Artery Atherosclerosis in the context of Mirtazapine toxicity
Manner:	Self-inflicted

Non-publication order: A Non-publication order pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) has been made in this inquest. A copy of the order can be found on the registry file.

Introduction

1 TH died at the South Coast Correctional Centre on 26 May 2022.

2 Because TH died whilst in custody, an inquest is required under sections 23 and 27 of the Coroners Act 2009 NSW (the Act).

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

The Coroner's role

4 An inquest is a public examination of the circumstances of a death. It provides an opportunity to closely consider what led to the death.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act namely:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of the person's death.

6 Another purpose of an inquest 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 the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding an Inquest a detailed coronial investigation was undertaken. Senior Constable Gavin Nethery compiled a brief of evidence and a post mortem report was obtained from a forensic pathologist as to the cause of death. TH's death was thoroughly investigated by SC Nethery who obtained relevant records and interviewed correctional officers, lay witnesses and ambulance officers. The Senior Constable also obtained relevant policy documents and CCTV footage.

8 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered into evidence during the Inquest. All that material has been considered in making the findings detailed below.

Background

9 TH was born on the 27th of July 1964 in the town of Swan Hill, Victoria. His early life could unfortunately be described as emotionally traumatic and occasionally violent, with his reportedly alcoholic father often being emotionally and physically abusive towards the entire family. With regards to his mother, TH has reported her as being afflicted by mental health issues, with a history of suicide attempts and drug abuse (Valium).

10 Throughout his early teenage years TH used cannabis and alcohol and spent time in various institutions. He performed work as a fruit picker, but unfortunately began committing crimes as a means of supporting himself. From as young as age twelve TH would frequent inner Sydney areas such as Kings Cross, abusing substances such as alcohol, cannabis and occasionally amphetamines, and has described himself as being 'out of control'.

Incarceration

11 Prior to his death TH had been incarcerated for over 40 years, having been arrested on 15 July 1981 in relation to two offences of murder committed on the 29th of June and the 13th of July 1981. TH was sixteen years of age when arrested.

12 TH was convicted of both murders and on the 23rd of September 1982 at the Central Criminal Court received two sentences of life imprisonment. He later applied for the fixing of minimum and additional terms to replace these sentences, and on the 3rd of June 1993 the Supreme Court of NSW substituted instead two minimum terms of twenty-four years penal servitude, commencing the 15th of July 1981

and expiring on the 14th of July 2005 - together with an additional term of “the remainder of his natural life”. The Court also deemed him eligible for parole on the 14th of July 2005.

13 TH’s history of custodial offences was very limited. TH was charged early on in his sentence with custody of a knife. In 1984 he was charged with conspiring to escape from lawful custody, and in 1989 for refusing to supply a urine sample.

14 Throughout his time in custody TH was housed in a number of correctional facilities, and in 2017 was moved to the South Coast Correctional Centre, South Nowra with a classification of C2 Minimum.

Parole Issues

15 Due to the nature of his charges TH was considered a serious offender, with the Serious Offenders Review Council (SORC) charged with providing recommendations on him such as classification and placement.

16 Throughout much of the later part of his time in custody TH had ongoing issues in relation to his parole. There is some suggestion in the materials that TH had thought he would automatically be released to parole when his minimum term came to an end in 2005. Whether or not that is the case it's clear that as at the time of his death TH was completely frustrated with both the SORC and the State Parole Authority (SPA).

17 SORC and SPA were conveying to TH that he was required to complete more courses to help address his violent propensities before he could be released back in to the community. TH, however, according to what he conveyed to other inmates, was of the view that he had completed all courses required of him prior to him being moved to the South Coast Correctional Centre. It was TH’s view there was a conspiracy between the authorities to keep him in custody.

18 A report authored by Amy Sowerby, Senior Psychologist South Coast Correctional Centre dated 26 May 2022 (likely prepared for the SPA hearing proposed for that date) reveals that TH was seen on the 15th and 29th of September 2021 by a Corrective Service NSW Serious Offenders Assessment Unit (SOAU) psychologist for the purposes of motivating him to engage in case plan goals. The report noted that in the second appointment TH reported not wanting to participate further, and that he did not attend the following three scheduled appointments of the 13 October 2021, 27 October 2021 and the 10 November 2021. Ms Sowerby’s report records TH as fluctuating between hope and ambivalence towards release, an expression of displeasure towards SORC and SPA for his repeated denial of parole, and his reported beliefs of parole continuing to be declined and of never being released. Also noted in the report was that during his final Corrective Service NSW Serious Offenders

Assessment Unit Psychology session dated 29 September 2021 he indicated that if he was not granted parole in 2022, he would, “carry out their death sentence”.

19 TH also told a fellow inmate that “they will never release me” and that “heads are going to role because I will die here in prison”.

20 During his investigation SC Nethery found, located under TH’s bed, two plastic tubs containing some personal belongings. Inside one of the tubs was a letter from the State Parole Authority dated the 6th of May 2022, regarding the 19th of May 2022 listing date for consideration of his parole being vacated and relisted to the 26 May 2022. Written on this letter in handwriting were the words, “SORC & Parole’s death sentence carried-out.”, with the relisted date of the 26 May 2022 being underlined.

Events leading up to TH’s death

21 TH had been housed at South Coast Correctional Centre since the 20th of July 2019 in a single unit cell, Cell 07-0105 of 7D Pod.

22 CCTV footage from inside Sector 5, Pod 7D from 4:55pm on the 25th of May 2022 to the time TH is located as deceased has revealed TH engaging in various activities.

23 TH left his cell at 2:35am on the 26th of May 2022, carrying an unknown item which he placed in the kitchen bins before returning to his cell. At 2:40am TH left his cell with a drink bottle, which he appeared to fill at the kitchen sink before emptying it and returning to his cell. At 2:42am TH again went to the kitchen where he appeared to use the tap and lean briefly over the sink before returning to his cell. At 2:42:49 am TH entered his cell and closed the door. This was the last time TH was seen alive. The footage does not show movement by TH into or out of his cell or any other person entering or leaving the cell from 2:43 onwards.

24 At 7:18am other inmates within the Pod were walking to morning muster when two of those inmates knocked on TH’s door, making attempts to open it but receiving no response.

25 At approximately 7:19am Correctional Officers attend Sector 5, 7D Pod for a head check and were informed by inmates that TH had not emerged from his cell. Approximately a minute later two Corrective Officers entered cell 07-0105, where they located TH lying face up in his bed, his hands raised on his body towards his shoulders. Immediately a Corrective Service officer sought to wake TH who was non-responsive, with no pulse found. A medical emergency was activated at 7:21am

with nursing staff arriving at the scene a minute later. Cardiopulmonary Resuscitation (CPR) was immediately performed on TH by Correctional Officers.

26 NSW Ambulance arrived at the scene at 7:32am. A decision was made to move TH from his cell to the common room area for better space management where resuscitation attempts were continued for 20 minutes. About 7:52am resuscitation was ceased, and TH was declared deceased.

Investigation following TH's Death

27 Police were called at 7:46am and arrived at the facility about 8:01am, with details being obtained from Corrective Officers as well as consent being obtained in order to examine the scene.

28 Crime Scene Officer Senior Constable Emerson arrived about 9:00am and began an examination. About 10:34am Detective Senior Constable Angus and the Officer in charge Senior Constable Gavin Nethery attended and spoke with General Duties Police and Correctives Officers about the incident. Detectives ascertained that there were no suspicious circumstances surrounding TH's death. SC Nethery observed there to be no signs of injuries upon TH's body. It was noted that TH's cell appeared clean and tidy in appearance.

29 During his investigation SC Nethery located a South Coast Correctional Centre document relating to searches conducted of TH's cell and observed that TH's cell had been searched 38 times since the 23rd of July 2019 - with three searches conducted in 2022 (5 February 2022, 13 February 2022 and the 16 April 2022). No items of interest or contraband were noted in any of these searches.

Cause of Death

30 An autopsy was performed on TH's body by Pathologist Dr Bernard I'Ons who found TH had severe chronic coronary artery atherosclerosis and a mildly enlarged heart and went on to comment that this degree of coronary artery stenosis was a high-risk factor for sudden cardiac death. Dr I'Ons

determined that the cause of TH's death was Chronic Coronary Artery Atherosclerosis in the context of Mirtazapine toxicity, with the other significant condition contributing to the death but not relating to the disease or condition causing it, being paracetamol toxicity.

31 Toxicology results obtained concerning TH showed toxic levels of mirtazapine and paracetamol. Ibuprofen, risperidone and paliperidone were also present.

32 It is clear that TH came into possession of, and ingested, medications not prescribed or administered to him.

33 During his investigation Senior Constable Nethery had reviewed CCTV footage from inside Sector 5, Pod 7D covering both the 24th and 25th of May 2022 up until the time TH was located deceased in his cell and could not identify anything suspicious or anything which revealed how TH ingested the medications found to be in his system at autopsy

34 Senior Constable Nethery further investigated this issue and found no evidence of how the medications came into TH's possession.In circumstances where regular searches of TH's cell were conducted, with no medications located, I accept that any further investigation into how TH came into possession of the medications would have been fruitless.

35 I accept the findings of the forensic pathologist in relation to TH's death and find that the death was self-inflicted. It is clear TH collected the medications he ultimately consumed for the purpose of deliberately overdosing. His comments to the psychologist and another inmate and his written note on the letter from the SPA both reveal an intention to end his own life.

Whether any recommendations required pursuant to s82 of the Coroners Act

36 On the evidence in this matter there are no recommendations to be made.

Findings under s81 of the Coroner's Act

37 For all the above detailed reasons I make the following findings:

Identity: The person who died is TH

Date: TH died on 26 May 2022

Place: TH died in his cell in, South Coast Correctional Centre NSW

Cause: Chronic Coronary Artery Atherosclerosis in the context of mirtazapine toxicity

Manner: Self-inflicted

Closing

38 I acknowledge and express my gratitude to the Coronial Advocate Mr Winter-Mirenzi, for his assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Senior Constable Nethery, for his work in the Coronial investigation and compiling the evidence for the inquest. I also thank the other legal representatives for their assistance.

39 On behalf of the Coroners Court of New South Wales, I offer my condolences to the family and friends of TH.

40 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales

12 December 2023