STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of AB
Hearing dates:	**22 October 2024**
Date of findings:	**31 October 2024**
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in Corrective Services NSW custody – self-inflicted intentional injury– whether mental health care and treatment concerns
File number:	2021/000024674
Representation:	S Chahrouk, Advocate Assisting the Coroner H Norris on behalf of the Justice Health and Forensic Mental Health Network A Poulios, DCJ Legal, on behalf of the Acting Commissioner of Corrective Services NSW
Non-publication order	Non-publication orders have been made pursuant to sections 74(1)(b) and 75(2)(b) of the *Coroners Act* 2009 (NSW) in relation to certain material contained within the brief of evidence and material that identifies AB or any relative of his. A copy of these orders is on the Registry file.
Findings:	AB died on 27 January 2021 at the Metropolitan Remand and Reception Centre, Silverwater The cause of AB's death was an incision/stab wound to the neck. AB died of a self-inflicted intentional injury while in the lawful custody of Corrective Services New South Wales

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of AB.

1 Introduction

1.1 On 28 November 2020 AB was refused bail at Parramatta Local Court and remanded to appear at Central Local Court on 5 February 2021. He was first held at Parklea Correctional Centre, but on 22 December 2020, was transferred to John Morony Correctional Centre (JMCC).

1.2 After a self-harm incident on 20 January 2021, AB was transferred to the Metropolitan Remand and Reception Centre (MRRC) and placed under the management of the Risk Intervention Team (RIT). He was placed in an observation cell.

1.3 On the evening of 27 January 2021, soon after he was returned to a regular cell, AB used toilet paper to cover the observation hatch of his cell, and again self-harmed by using a broken razor blade to cause an injury to his neck. The incident was discovered during regular half hourly observations by Corrective Services NSW (CSNSW) staff. Although medical assistance arrived quickly, AB could not be revived. AB was 34 years old at the time of his death.

2 The nature of the inquest

2.1 Under the *Coroners Act* 2009 ('the Act') a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their liberty, CSNSW assumes responsibility for the care of that person as the person is unable to independently take steps to seek medical assistance or other care. The combined effect of sections 23 and 27 of the Act is that it is mandatory for a senior coroner to hold an inquest where a person dies while in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that

CSNSW has cared for a person in its custody in a reasonable and appropriate way.

2.3 AB's former partner, JM, wished for an inquest to be held into AB's death. JM asked that the following issues be explored:

- whether AB was adequately monitored after his first self-harm attempt to ensure that he did not self-harm again;
- whether AB's placement into a normal cell on 27 January 2021 was appropriate;
- whether AB was provided with adequate and appropriate mental health care while he was in custody; and
- how AB was able to access items with which to commit self-harm.

2.4 During the coronial investigation, sufficient information was obtained to respond to the issues raised by JM, and to show that both CSNSW and the Justice Health and Forensic Mental Health Network (Justice Health) had made changes to their policy and practice in response to issues identified as a result of AB's death. This significantly narrowed the scope of the inquest, which ultimately focused only on the statutory findings under s 81 and involved the tendering of the brief of evidence and some brief oral evidence given by the Officer in Charge, Detective Senior Constable Trong Nguyen.

3 AB's life

3.1 Before moving to a consideration of the circumstances of AB's death, it is important to acknowledge his life in a brief and hopefully meaningful way.

3.2 AB was born on 23 August 1986 in Darlinghurst. He was an only child. His father left when he was very young, so he was raised by his mother, his auntie, and his grandmother. His family was not well off and lived in Housing Commission accommodation. AB was raised predominantly in the Mt Druitt and Blacktown areas.

3.3 AB finished school in year 9, having been suspended on a few occasions for fighting. He did not complete any further education or training after leaving school. He never had consistent work but did do some casual labouring at various times over the years.

3.4 When AB was 16 years old his mother died from a drug overdose. This affected AB greatly and, according to JM, he began to use drugs as a coping mechanism.

3.5 AB was first charged with a criminal offence at the age of 16. Over the years he accumulated

a significant criminal record in both NSW and the ACT. There is no doubt that his drug use played a significant part in his offending.

3.6 In 2007 in Canberra, AB met JM. The relationship had its challenges as both AB and JM used illicit drugs. JM ceased using drugs in 2012 when the couple's son, K, was born. Although AB tried to stop his drug use, despite several stints on the methadone program, he was unable to do so.

3.7 AB's continued drug use after K's birth caused conflict in his relationship with JM, which was exacerbated by AB's continued contact with the justice system. AB was sent to gaol in 2014 for 5 years for his involvement in a robbery in Canberra. According to JM, AB was never the same after this time in gaol.

3.8 Although AB's relationship with JM ended in 2018, they remained in contact.

4 AB's mental health history

4.1 AB was generally well in terms of his physical health, although from a young age he struggled with substance abuse. He began using cannabis at age 13 and cocaine, heroin, and methamphetamine from the age of 16. He also abused Xanax. At various times AB was on the methadone and Buvidal programs.

4.2 In 2013, AB suffered a seizure after accidentally overdosing and was assessed by a forensic psychologist who noted major mood disorder or psychosis. He was prescribed with antipsychotic medication. Despite this, AB appears not to have been taking any medication at the time of his arrest on 27 November 2020.

4.3 Around Christmas 2018, AB was admitted into Campbelltown Hospital after suffering a seizure. He reported four days of bingeing on prohibited substances and not sleeping. It was recommended that he take anti-epilepsy medication to prevent further seizures, however it appeared that AB denied having had a history of seizures during subsequent entries into custody.

4.4 JM believed that AB's mental health deteriorated significantly in the 12 months before his death. She noted that AB was '*really down and quiet…started talking about death…told me that his mum had died at about his age and he would die too*.' The last time JM saw AB was in July or August 2020. After his return into custody in November 2020, he stopped contacting her.

4.5 On 19 June 2020, AB was found by Police to be in possession of three small razor blades in his pants pocket which he said he was going to use that night to cut his throat and kill himself.

4.6 On the Intake Screening Questionnaire that AB completed after he entered CSNSW custody on 29 November 2020, he disclosed that he had a history of PTSD and drug use but said that he had never self-harmed nor attempted suicide and had no thoughts of doing so. He denied any mental health history.

4.7 Despite AB's denial of any mental health history, there is some suggestion in his Justice Health records of 'mental health issues' and a previous suicide attempt by overdose in or about 2005. There is no evidence, however, that AB had ever been formally diagnosed with any mental health conditions.

5 AB's time in CSNSW custody after 27 November 2020

5.1 On 27 November 2020 AB was charged with several offences including remain on inclosed lands without lawful excuse, stalk/intimidate intend to cause physical or mental harm, and assaulting police. His custody management records indicate that he showed signs of mental illness while in police custody after his arrest. At the time of his arrest, he was on bail for other offences and was also in breach of an ACT parole order that was due to expire on 19 May 2021.

5.2 AB was refused bail on 28 November 2020 at Parramatta Local Court and remanded to appear at Central Local Court on 5 February 2021. He was first held at Parklea Correctional Centre but was transferred to JMCC on 22 December 2020.

5.3 On 20 January 2021 AB attempted self-harm by cutting both inner arms with a razor blade. He was transferred to Nepean Hospital for treatment.

5.4 On 22 January 2021, after his release from hospital, a Justice Health nurse conducted a psychiatric assessment of AB. He is described in the notes from this assessment as *'visibly upset with no eye contact at all with one leg shaking constantly*'. When asked to rate his day on a scale of 1 to 10 (1 being worst and 10 being best), AB recorded a score of 1 'nothing can make it better'. As a result of the self-harm incident, AB was placed under a RIT Management Plan, which recommended '*for placement in…camera cell with continuous CCTV observations. For 15 min physical observation by CSNSW (sight and sound)…Nil*

property in cell, nil sharps…For daily RIT review.'

5.5 On 23 January 2021 AB was transferred to MRRC, where he was initially housed in D Block (Darcy) cell 33. This cell was an observation cell where the front of the cell is covered in plexiglass, inmates are not permitted to have their belongings with them, and they are monitored by CCTV.

5.6 On the morning of 25 of January 2021, AB was reviewed by RIT officers. He reported that he was being stood over at the JMCC due to his associations with Outlaw Motorcycle Gangs (OMCG) and resorted to self-harm so he could be transferred to another gaol for his own safety. As there was no previous recorded history of self-harm or suicidal ideation in custody or in the community AB was assessed to be at low risk of immediate self-harm and was discharged from RIT management.

5.7 At 12:30pm on the same day, AB was further assessed by a mental health nurse. He was deemed to be at a low risk of suicide. The medical notes recorded no history of mental illness, and no obvious psychotic symptoms and disturbances in mood. AB denied any intention to self-harm or commit suicide. He showed no interest in the interview. The mental health nurse saw no basis to challenge the decision to discharge AB from RIT management. He recommended that AB be placed in a two-out cell and self-refer to mental health services when needed. A further review was scheduled for 22 February 2021.

5.8 On 26 January 2021 AB was moved to D Block observation cell 44.

5.9 At 8:59 pm on 27 January 2021, AB was transferred to cell 64, a regular cell in Darcy block, as he had been classified as no longer needing RIT management and another inmate who was under RIT management required an observation cell. This cell had a steel door and an eye height viewing window. AB was the single occupant of this cell because CSNSW officers needed to ensure he had no issues with other inmates before placing him in a shared cell. He was subject to well-being checks every 30 minutes.

5.10 About 10:21 pm CSNSW officer Hillhouse conducted a walkthrough as part of his duties. This was captured on CCTV. He '*didn't see anything out of the ordinary*' in terms of AB's wellbeing. Officer Hillhouse conducted another walkthrough at 10:48 pm. He noticed that there was toilet paper on the hatch of the observation window obscuring the view inside the cell. He opened the cell door and saw AB lying motionless in the shower in a pool of

blood. Officer Hillhouse called for urgent medical attention, but nothing could be done to save AB.

5.11 AB was pronounced deceased at 11:05 pm.

6 Investigations after AB's death

Police investigation

6.1 Police were contacted and attended MRRC at 11:24 pm on 27 January 2021. An investigation into AB's death was commenced.

6.2 The words 'Glory to Go God' appeared to have been written by AB in blood on the cell wall. Half a razorblade was later found in the sink. The investigation found no evidence to suggest that AB had any connection with OMCG members.

6.3 The police investigation concluded that there were no suspicious circumstances associated with AB's death and concluded that his death had been deliberately self-inflicted using a broken razor blade.

Postmortem examination

6.4 On 1 February 2021, forensic pathologist, Dr Rianie Janse Van Vuuren performed an external autopsy examination on AB's remains. This examination identified a diagonal 45 x 12 mm wound on the left side of AB's neck. The track of the wound extended through the left internal jugular vein into the soft tissues of the neck.

6.5 The examination found no alcohol or drugs of abuse in the postmortem blood. Also noted were two recent surgically treated wounds on the right upper arm and the left forearm.

6.6 Dr Van Vuuren concluded that the cause of AB's death was an incision/stab wound to the left side of his neck.

Serious Incident Investigation Report

6.7 CSNSW Investigations investigated the circumstances of AB's death. All available CSNSW documents and records kept in relation to AB were collected and reviewed, including his case management files, warrant files, case notes, records kept on the offender integrated management system, and incident reports submitted by all relevant corrective officers involved in AB's first self-harm incident, his subsequent management under RIT and his final

movement and placement into cell 64. All relevant policies and procedures were also reviewed.

6.8 After a review of the evidence, investigators concluded that the origin of the razor blade fragment was most likely from within cell 64, the cell into which AB was transferred from observation cell 44. CCTV evidence showed that cell 64 was last occupied by other inmates at 12:44pm on 27 January and was not searched prior to AB being placed there. The fact that cell 64 was not searched before AB's placement did not, however, constitute a breach of any applicable Custodial Operating Policy and Procedures (COPP) in existence at the time of AB's death.

6.9 The CSNSW investigator determined that by the time AB was found by officers in cell 64 on the night of 27 January 2021 he was probably already deceased due to a deliberate act of self-harm. The investigation also found that AB was managed in accordance with CSNSW policies and procedures, with the following exceptions found to have contributed to his death:

- on the 27th of January 2021, despite the two out cell recommendation, he was placed into cell 64 alone; and
- cell 64 was not searched prior to his placement and may have provided him with access to means of inflicting self-harm.

<u>Report from forensic psychiatrist, Dr Danny Sullivan</u>

6.10 During the coronial investigation, a professional opinion was sought from Consultant Forensic Psychiatrist, Dr Danny Sullivan, in relation to specific issues related to AB's assessment and management in custody.

6.11 Dr Sullivan made the following comments regarding AB's mental health care during his time in CSNSW custody immediately prior to his death:

- The mental health screening of AB on arrival at JMCC was limited in scope. Nevertheless, clinical staff were aware of AB's recent progression and his history via available records and no formal mental health intervention was warranted at the time.
- Both CSNSW and Justice Health took appropriate action in response to AB's self-harm incident on 20 January 2021. Although efforts were made without success to connect

AB to family and friends via telephone, it may have also been appropriate to refer him to the chaplain or other informal support services in custody.

- The discharge from Nepean Hospital on the 22 January 2021 following AB's first self-harm attempt appeared to be appropriate given that the purpose of the admission was the acute surgical treatment of lacerations to his arms.
- The transfer of AB to MRRC was appropriate given that MRRC has the Mental Health Screening Unit and associated facilities which are better able to manage people with suspected or confirmed mental health issues. Although AB may not have had a reception assessment on 23 January apart from COVID it was unlikely this would have affected his management given he was already subject to RIT oversight.
- AB's accommodation placement from 20 - 27 January 2021 was appropriate.
- It was unclear whether AB had been referred for psychiatric review, which would have been warranted given the seriousness of his self-harm which required transfer and surgical repair of injuries. This would have provided a high-level assessment of ongoing risk in order to identify and manage any mental health disorder which might have underpinned the deliberate self-harm episode.
- It may have been preferable to have relied upon a more prolonged period of demonstrated, stabilised, improvement in mental state prior to moving AB from a safe cell into cell 64, although there are limited numbers of safe cells and placement in safe cells is not conducive to improvement in mental state. Maintaining an inmate with risk of self-harm in such restrictive conditions for prolonged periods is impracticable in the corrective environment and unlikely to reduce the overall number of custodial suicides.
- In AB's case, in the absence of evidence of remediable risk factors such as diagnosed mental illnesses that may respond to treatment, there was limited opportunity to change the trajectory of his suicidal intent. Although a shared cell reduces the likelihood of completion of suicide or self-harm, it may not have been sufficient to deter AB from committing further self-harm given indications of premeditation and preparation.

6.12 Dr Sullivan made the following recommendations:

- It is appropriate for a patient whose self-harm has required transfer out and surgical repair of injuries to have a psychiatric review upon return to prison. This would provide

a high-level assessment of ongoing risk to identify and manage any mental health disorder which might have underpinned a deliberate self-harm episode.

- Justice Health may wish to seek opportunity to reduce the number of mental health staff involved in the RIT process and perhaps increase the opportunity for consistent staffing to provide RIT assessments.
- Justice Health may wish to consider remedying the lack of clear guidelines on the timeframe for an inmate to be maintained under restrictive conditions to mitigate the risk of suicide.
- Justice Health may wish to consider ways to improve visibility of an inmate's mental health history via alert system or summary available at the commencement of an electronic medical record.

7 Changes to Justice Health and CSNSW policies and procedures since AB's death

CSNSW

7.1 Since AB's death the COPP have been amended to provide that prior to an inmate's cell placement, the cell must be searched and cleared of any contraband or unapproved items that may be used to self-harm or to harm others. This applies to any inmate that is subject to a Mandatory Notification, Immediate Support Plan or Risk Intervention Team Management Plan.

7.2 Relevant forms including the mandatory notification form, inmate support plan, risk intervention management and the discharge plan form, have been updated with the addition of a checkbox to remind staff to search cells before placement of applicable inmates.

Justice Health

7.3 The relevant Justice Health NSW Policy *Clinical Care of People Who May be Suicidal* was updated in November 2021 following AB's death to specifically note that patients who require surgical intervention as a result of suicide or deliberate self-harm behaviour, should be referred for a specialist mental health assessment.

7.4 The Justice Health Patient Administration System and the electronic Health System include alerts that allow clinicians to quickly view key concerns previously identified for a patient. The alerts can also specify the date when the condition or concern started and ended. Any

clinician can enter, update, or remove the alerts to allow for an up-to-date overview of the inmate's health and mental health history. It is noted that AB did not disclose any mental health history until his first suicide attempt on 20 January 2021. Alerts were created on the same day. The updated *Clinical Care of People Who May be Suicidal* policy now requires an alert to be placed by the Justice Health clinician who was involved in a RIT assessment and/or the management of the patient. The entry must be made identifying which of the four categories occurred (report of a risk of self-harm or suicide; threat of self-harm or suicide; act of self-harm; or suicide attempt) and the RIT review date.

7.5 There are no applicable Justice Health policies that require consistency of mental health staff to be involved in the RIT process and mental health assessment of inmates, although in practice in many centres a level of consistency in staff is achieved informally. It is also challenging to achieve this at the MRRC due to resourcing, shift scheduling and the number of patients but having a core group of staff who are on the RIT provides a degree of consistency.

8 Conclusions

8.1 After considering all the evidence gathered from the coronial investigation, no organisation or individual was identified as having a sufficient interest in the subject matter of the coronial proceedings in accordance with section 57(1) of the Act, although JM, CSNSW, and Justice Health were advised of the inquest.

8.2 An inquest is mandatory because AB died whilst in the custody of CSNSW. However, unlike most other inquests, no issues apart from the statutory findings pursuant to section 81 of the Act were identified after the coronial investigation which required discrete examination during the inquest.

9 Consideration

9.1 Having regard to the above, the available evidence establishes the following:

- At the time of his death, AB was in the lawful custody of CSNSW, having been refused bail at Parramatta Local Court on 28 November 2020;
- at the time he was accepted into the custody of CSNSW AB did not disclose any mental health issues or any thoughts of self-harm;

- there was no evidence that AB had ever been formally diagnosed with any mental health condition;
- AB was appropriately treated after he was returned to custody following his first self-harm incident on 20 January 2021 and appropriately monitored to ensure that he did not self-harm again;
- AB's ongoing treatment and the decision to discharge AB from RIT management may have benefitted from psychiatric review, changes to Justice Health policy since AB's death make it unnecessary to make any recommendations in this regard;
- although the decision to place AB in a single cell was contrary to the recommendation that he be placed in a two-out cell, the decision to do so was reasonable in circumstances where AB had been discharged from RIT management, there was considerable pressure to find an observation cell for another inmate who was experiencing a mental health episode, and there was a need to check whether there were any restrictions on his contact with other inmates prior to placing him in a two out cell; and
- although the failure to search cell 64 prior to AB being placed there contributed to his ability to deliberately self-inflict his own death, changes made to CSNSW policy make it unnecessary to make any recommendations in this regard.

10 Findings

10.1 I would like to express my thanks to the Officer in Charge, Detective Senior Constable Trong Nguyen, Advocate, Samer Chahrouk, and former Advocate, Kai Jiang, for all the work they have done in investigating this matter and preparing it for inquest.

10.2 The findings I make under section 81(1) of the Act are:

Identity

The person who died was AB.

Date of death

AB died on 27 January 2021.

Place of death

AB died at the Metropolitan Remand and Reception Centre, Silverwater, NSW.

Cause of death

The cause of AB's death was an incision/stab wound to the neck.

Manner of death

AB died of a self-inflicted intentional injury while in the lawful custody of Corrective Services NSW.

10.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to AB's former partner, JM, to his son, K, to members of AB's extended family, and to his friends for their tragic loss.

10.4 I close this inquest.

Magistrate Kasey Pearce

Deputy State Coroner

Coroners Court of New South Wales

31 October 2024