CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr S
Hearing date:	9 April 2024 – 12 April 2024
Date of findings:	12 December 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest – death of a person in lawful custody – self-inflicted intentional death
File number:	2018/15711
Representation:	Counsel Assisting the inquest: S McGee of Counsel instructed by the NSW Crown Solicitor's Office. The Justice Health and Forensic Mental Health Network and Registered Nurse Sandra Jenkins: J Harris of Counsel instructed by Makinson d'Apice Lawyers. The Acting Commissioner of Corrective Services NSW: G Lewer of Counsel instructed by the Department of Communities and Justice Legal. Janette Beer: L Fernandez of Counsel instructed by Chris Gall Lawyer. Sutopa Sarker: R Deppeler of Counsel instructed by McNally Jones Staff Lawyers.

Findings:	**Identity** The person who died is Mr S. **Date of death**: Mr S died between 14 and 15 January 2018. **Place of death**: Mr S died at Long Bay Correctional Centre, Sydney. **Cause of death:** Mr S died as a result of hanging. **Manner of death:** Mr S's death was an intentional self inflicted death, while he was in lawful custody.
Non-publication orders	Orders prohibiting the publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act) have been made in this inquest. A copy of these orders, and orders made pursuant to section 65(4) of the Act, can be found on the Registry file.

Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] 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 Mr S.

Introduction

1. Mr S aged 57 years died in Long Bay Correctional Complex, at some time between the evening of 14 January 2018 and the morning of 15 January 2018.

2. Mr S had been in custody since 7 March 2017. He had been charged with the murder of his wife Ms K, and he was refused bail. Mr S made extensive admissions to police that he had killed his wife. However, he took his own life in custody before he entered a plea or stood trial for this offence.

3. An inquest into the circumstances of Mr S's death is mandatory, pursuant to sections 23 and 27(1) of the Act, as he was in lawful custody at the time of his death.

The role of the Coroner

4. Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of their death.

5. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

6. Mr S was born in Singapore to parents of Indian background. When he was a young boy his family sent him to India to work on a relative's farm. There is evidence that as a result Mr S was denied the education which his siblings received, and that he came to resent this fact. Reportedly he taught himself to read, and as an adult he worked as a factory supervisor.

7. Mr S emigrated to Australia in about 1983. Approximately ten years later he returned to India for the purpose of marrying Ms K, who was fourteen years younger than he. Their marriage was an arranged one. After the wedding Mr S retuned to Australia, where Ms K joined him the following year. Their sons PS and AS were born in 1996 and 1999 respectively.

8. Both Ms K and Mr S were of Sikh Indian background, and they were members of the Sikh temple community at Glenwood. Ms K worked as an assistant nurse in aged care. Her friends and colleagues admired her as a good friend and a selfless mother.

9. The marriage was an abusive one, and it appears that Ms K remained in the family home mainly for the sake of her sons. At the time Mr S killed her, he had become aware that she was making plans to leave the family home. Her sons had by then finished their secondary schooling.

10. On the morning of 7 March 2017, Mr S purchased a knife, then returned home and stabbed his wife. She fell to the floor and he suffocated her. He then left the house. Their younger son AS found his mother's body some hours later, lying on the kitchen floor covered with a blanket.

11. After killing his wife Mr S tried unsuccessfully to hang himself, before being arrested and charged.

12. Mr S's sons PS and AS did not want to participate in this inquest, which is understandable. PS and AS witnessed domestic conflict and abuse while they were growing up. This culminated in the horrific murder of their mother by their father, followed by their father's incarceration, and his suicide ten months later.

13. It is difficult to imagine a more traumatising family history for two young people. So it is very understandable that the boys, now young men, had no wish to relive the tragedy of their parents' deaths by participating in these inquests.

The issues at the inquest.

14. The inquest examined the following issues:

    1) What was the cause and manner of Mr S's death?

    2) What was Mr S's mental state in the weeks leading up to his death?

    3) Was the mental health care which Mr S received while in custody appropriate?

    4) What were the circumstances in which Mr S came to be housed in a cell alone on 14 January 2018, when it had been recommended by custodial health staff that he be placed in a 'two out' cell?

The cause and manner of Mr S's death

15. Forensic pathologist Dr Rebecca Irvine performed an autopsy on 17 January 2018. She concluded that the cause of Mr S's death was hanging.

16. Toxicological analysis detected what Dr Irvine described as *'a toxic to lethal blood range concentration of fluoxetine'.* Fluoxetine is an antidepressant medication, with which Mr S had been prescribed while he was in custody. The analysis also detected nontoxic concentrations of irbesartan (an antihypertensive medication), metformin (used to treat diabetes) and quetiapine which is an antipsychotic medication.

17. In light of the toxicological results, a report was sought from forensic toxicologist Professor Alison Jones. She provided an expert report and gave oral evidence at the inquest.

18. Professor Jones' opinion was that the likely cause of Mr S's death was *'a range of factors that include the fluoxetine, the hypoxia and of course the hanging itself'.*

19. In brief, Professor Jones said she could not exclude the possibility that Mr S's ingestion of the fluoxetine had contributed to his death. In her opinion, since one of the effects of hanging is to reduce oxygen supply to the person's blood, Mr S's heart was likely '*more sensitive to the effects of any drugs that interfere with the rhythm of the heart*'.

20. Dr Irvine was asked if Professor Jones' opinion caused her to revise her finding as to the cause of Mr S's death. It did not. Dr Irvine told the inquest that there would not have been sufficient time for the fluoxetine to impact upon Mr S's condition, given how rapidly a person becomes unconscious when intentionally hanging themselves. In Dr Irvine's opinion therefore, the presence of the fluoxetine was '*superfluous to the cause of death'.* Dr Irvine was in addition emphatic that had the medications not been present, Mr S would still have died as a result of hanging.

21. I accept the submission of Counsel Assisting that in circumstances where Dr Irvine identified a cause of death which was independently fatal, namely hanging, the cause of death should be given as '*hanging*'.

22. I note further that there is no evidence that the relatively high concentrations of fluoxetine in Mr S's post mortem blood were due to any oversights on the part of custodial health staff.

What was Mr S's mental state in the weeks leading up to his death?

23. When Mr S entered custody on 7 March 2017 his legal representatives commenced preparations for a possible defence to his murder charge, based on mental illness. Ultimately however, Mr S took his own life before the commencement of his trial in the NSW Supreme Court.

24. As part of these preparations, Mr S was psychiatrically assessed on three occasions in 2017. The assessing psychiatrists were Dr Anthony Samuels and Dr Andrew Ellis.

25. Both psychiatrists concluded that at the time he killed Ms K, Mr S was experiencing a major depressive episode with psychotic features, the latter characterised by a delusional belief of his wife's infidelity. The psychiatrists also considered that Mr S met the diagnostic criteria for alcohol use disorder. They adhered to these diagnoses after having been provided with evidence that over a lengthy period, Mr S had inflicted physical, emotional and psychological abuse upon Ms K.

26. It is probable that for the entire period Mr S was in custody, that is from 7 March 2017 until his death ten months later, he experienced low mood and sporadically psychotic symptoms.

Mr S's Justice Health reviews

27. The Justice Health and Forensic Mental Health Network [Justice Health] provides physical and mental health services to NSW inmates.

28. While he was in custody, Mr S received regular reviews and treatment for his physical health conditions of Type 2 diabetes, hyperthyroidism and hypertension.

29. Regarding his mental health, Mr S had a number of screening assessments and interviews in his first few days in custody. These recorded that he presented with low mood, but that he denied ongoing thoughts of self harm or suicidal ideation.

30. On 9 March 2017, Mr S was assessed as at medium risk of harm to himself. However, a further review on 11 March 2017 assessed this risk as low because he was able to verbally guarantee his personal safety.

31. Mr S had a mental health assessment by a mental health nurse on 27 May 2017. Reportedly his affect was '*anxious/restricted'* and he said he felt depressed. However, he reported no thoughts of suicide or of harm to others. He was placed on a wait list to see a psychiatrist.

32. Mr S's psychiatric review took place on 5 June 2017. It was performed by Dr Amor, a Visiting Medical Officer employed by Justice Health.

33. Dr Amor recorded that Mr S had probable significant depression and possible psychotic symptoms. He prescribed the antidepressant medication fluoxetine.

34. In the following months Mr S was again reviewed by Dr Amor, and by mental health registered nurses. It was recorded that he was suffering a depressive illness with psychotic symptoms, which appeared to be resolving with treatment. In these reviews Mr S reported that his mood was slowly improving.

35. Throughout September 2017, Mr S was transferred to different correctional centres, before being placed in the Long Bay Correctional Centre Hospital on 17 October 2017. In a review on 30 October 2017, he said that he now felt low in mood once again. Among other things he was worried about the mental health of his son AS.

Mr S's review on 22 November 2017

36. On 22 November 2017, Mr S was reviewed by Justice Health psychiatrist Dr Matthew Hearps. Mr S told Dr Hearps that he continued to feel depressed, and that he had been hearing his wife's voice in his head saying, '*come and join me'*. However, he said he would not harm himself because his son needed him.

37. Dr Hearps decided to increase Mr S's dosage of fluoxetine and to maintain use of the antipsychotic quetiapine, with which Mr S had been prescribed earlier that month. Dr Hearps directed that administration of these medications to Mr S be supervised.

38. Notably, Dr Hearps also made a recommendation that Mr S be placed in a group cell, also known as a *'two out'* cell. He said this was because he considered Mr S to be at risk of self harm, and that this risk could be mitigated by the presence of another person in his cell.

39. In accordance with usual procedure, Dr Hearps requested that a Justice Health nurse record this recommendation on Mr S's Health Problem Notification Form [HPNF].

40. HPNF's are maintained by Justice Health Staff. Their purpose is to communicate to correctional officers certain Justice Health advice and recommendations about an inmate. Usually this information concerns cell placement, and possible signs of illness. The cell placement recommendation guides correctional staff in deciding appropriate accommodation for the inmate.

41. Dr Hearps asked Registered Nurse Sandra Jenkins to fill in the HPNF for Mr S. She did so, preparing an electronic version and then making a hard copy which she signed. It recorded '*2 out cell placement as per psychiatrist review 22/11/17'.*

42. It is Corrective Services procedure that when a recommendation for two out cell accommodation is accepted, a formal alert to this effect is created on the inmate's file within the Offender Integrated System [OIMS]. The OIMS system is operated by Corrective Services staff. But for reasons which are not clear, in Mr S's case no such alert was created.

43. Mr S had another, and final, review by Dr Hearps on 13 December 2017. Dr Hearps' impression was of depression, with some improvement on treatment. He reduced Mr S's dosage of quetiapine, as he had not reported any psychotic symptoms. He was to have a mental health nurse review in six weeks.

44. The next day, Mr S was transferred to the Metropolitan Special Programs Centre [MSPC] at Long Bay Correctional Centre.

<u>At the MSPC</u>

45. Mr S was assigned to 9 Wing of the MSPC on 14 December 2017.

46. However, neither the OIMS system, nor the transfer paperwork, recorded that Mr S was to be placed in a two out cell. And when he arrived at the MSPC, a placement form was created in which a two out cell placement was first circled, and then crossed out. The option for '*normal cell placement'* was instead circled.

47. It is understood that '*normal cell placement'* means that the inmate is considered suitable for placement in a cell either on his or her own, or with another person. How this form came to be completed in this way is examined later in these findings.

48. As it happened, Mr S was placed in a cell with another inmate until 11 January 2018.

49. On 4 January 2018, Mr S was reviewed by psychologist Clare Fookes. Ms Fookes found Mr S to be polite, but not very forthcoming. He told her that he did not have any thoughts of suicide or self harm.

50. On 10 and 12 January 2018, Mr S had phone conversations with two relatives. In these he expressed distress because his sons did not want to speak with him on the phone. He also told his relatives that he wouldn't be present by the time his lawyers visited him in February. One of the relatives urged him not to do anything to harm himself.

The events of 14 January 2018

51. On the nights of 11 and 12 January 2018, and again on the night of 14 January 2018, Mr S was housed in a cell alone. He was given his evening medication at about 6.00pm on 14 January 2018. This was the last time he was seen alive.

52. At approximately 7.30am on 15 January 2018, Mr S was discovered by correctional staff, hanging from the window bars at the back of his cell. He had used his bed sheets as a ligature. He could not be revived, and he was pronounced deceased.

53. I will now address the issues at the inquest.

Was the mental health care which Mr S received while in custody appropriate?

54. Independent forensic psychiatrist Dr Adam Martin was asked to review Mr S's records and provide his opinion as to the appropriateness of his custodial mental health care.

55. In Dr Martin's opinion, at the time of his death Mr S was likely in a highly distressed state, in the context of major depression with psychotic features. He considered that Mr S was at high long term risk of suicide and violence, due to his background of emotional dysregulation, poor coping skills, alcohol abuse and problem gambling.

56. In his evidence at the inquest, Dr Martin maintained the view that at the time of his death Mr S was at high risk of self harm. He agreed however that it was a complex and difficult task to predict if and when such a patient would take their own life.

57. Dr Martin said that if Mr S been his own patient in the community, he would consider his risk of self harm to be such that he would probably require hospitalisation. Dr Martin acknowledged however that within the custodial environment, there are insufficient hospital placements to accommodate voluntary mental health admissions.

58. In addition, Dr Martin noted that at Dr Hearps' final assessment on 13 December 2017, Mr S had reported feeling some improvement in mood. He had also

appeared willing to comply with his medication regime. Dr Martin agreed that for these reasons, there was probably not a basis at that time for him to be admitted to the Long Bay Hospital.

59. Dr Martin further agreed that it had been appropriate for Dr Hearps to recommend, as a suicide mitigation risk, that Mr S be placed in a two out cell.

60. In summary, Dr Martin was not critical of the competence of, or treatment provided by, any health clinicians who were involved in Mr S's care while he was in custody.

61. In closing submissions, Counsel Assisting stated that it was open to the court to find that the mental health care which Mr S received was within the standard expected of custodial health.

62. I accept this submission.

63. It remains unclear how it was that Mr S's levels of fluoxetine were high at the time of his death. It is possible that he had managed to stockpile his medication; or that he had found a way of illicitly obtaining additional fluoxetine.

What were the circumstances in which Mr S came to be housed in a cell alone on 14 January 2018?

64. I have noted that according to the recommendation of custodial health staff, Mr S needed to be accommodated in a 'two out' cell.

65. When Mr S arrived at the MSPC on 14 December 2017, he underwent a reception interview which was conducted by Assistant Superintendent Janette Beer together with Services and Programs Officer Sutopa Sarker.

66. Ms Beer is a senior officer who has many years' experience conducting reception interviews in correctional centres.

67. On the morning of 14 December 2017, Ms Beer was required to conduct a number of reception interviews. She was also unusually busy with work generated by a Benchmarking Restructure which was underway at the time.

68. Ms Beer told the court that before she interviewed a new inmate, her practice was to check for any alerts on the inmate's file and the OIMS system. In Mr S's case, the only recorded alert (which had by then expired) related to the need for his medication to be supervised. Ms Beer also checked Mr S's Inmate Profile Document, noting that there was a history of self harm but that no such incident had been recorded since 9 March 2017.

69. Ms Beer then saw that Mr S's most recent HPNF had recommended two out placement. She therefore circled '*two out placement'* on his Reception Interview Form.

70. At 3.14pm that afternoon Ms Beer was still working, although she had been due to end her shift at 3.00pm. She came to the decision that she had mis-read Mr S's

HPNF recommendation. She therefore crossed out the *'two out placement'* notation and circled *'normal cell placement'* instead.

71. At the inquest Ms Beer explained to the court why, at the time, she had thought she had mis-read Mr S's HPNF recommendation. She said that it was very likely she would have had a discussion with the Wing Officer for the area where Mr S had been placed. The Wing Office had listed him for '*normal cell placement'*. On the white board for that area, Mr S's name was not included within the group of inmates who were listed for two out placement. Furthermore, there was no relevant alert on Mr S's OIMS file, and his transfer paperwork merely noted: *'Self harm risk: Inactive'.*

72. Ms Beer therefore concluded that since all these features indicated that the intention was for Mr S to have *'normal cell placement',* she must have mis-read his HPNF that morning. In other words, when Ms Beer considered the question of Mr S's cell placement, she relied on the absence of '*two out cell placement'* indications in places where she would expect to find these. She therefore amended the HPNF to direct '*normal cell placement'* for Mr S.

73. At the inquest Ms Beer accepted that the most reliable indication of an inmate's recommended placement was their most recent HPNF, and further, that there was an expectation that correctional staff would have regard to the recommendation contained within the HPNF. She acknowledged that she had made an error that afternoon.

74. Since that time, Ms Beer has sought to reduce the risk of such errors being repeated, by making her own recommendations for the simplification of the HPNF. The court heard that Justice Health has adopted her suggestions in recent changes which it has made to the HPNF (see below).

75. I accept the submission of Counsel Assisting, that the error which resulted in Mr S being accommodated alone in his cell on the nights of 11, 12 and 14 January 2018 was a human error, and not a systemic one.

76. I further accept that Ms Beer's error was the result of a genuine misunderstanding of the circumstances, for which she has taken responsibility. In all the circumstances it would not be appropriate to single her out for adverse comment in these findings.

<u>Changes to the HPNF</u>

77. On behalf of the Acting Commissioner for Corrective Services, Ms Lewer acknowledged that Mr S ought to have been placed in a cell with another inmate and expressed regret for his death.

78. The court heard that since Mr S's death, Justice Health has taken the following steps:

- in 2020 joint Justice Health/Corrective Services training took place, to improve staff understanding of how to complete and communicate information in an HPNF, and how to interpret its contents

- in February 2024, the HPNF was amended to make clearer what the options are for an inmate's cell placement.

79. In addition, Justice Health is developing an HPNF e-form, in consultation with Corrective Services staff. The focus will be upon maximising the communications between Justice Health staff and correctional officers, in relation to the inmate's health conditions.

The question of recommendations

80. Counsel Assisting submitted that in light of the above reforms, it was not necessary or desirable for the court to make any recommendations. I accept this submission.

Conclusion

81. I express to the sons of Ms K and Mr S my sincere sympathy for the loss of both their parents in such tragic circumstances.

82. I thank Counsel Assisting Ms McGee and the Assisting team for their work in the preparation and conduct of this inquest. I thank also the Officer in Charge of the coronial investigation, Detective Inspector Meagan Finlay and the previous Officer in Charge (former) Detective Senior Constable Michael Cambridge for the preparation of the brief of evidence.

Findings required by s81(1)

83. 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.

Identity
The person who died is Mr S.

Date of death:
Mr S died between 14 and 15 January 2018.

Place of death:
Mr S died at Long Bay Correctional Centre, Sydney.

Cause of death:
Mr S died as a result of hanging.

Manner of death:
Mr S's death was an intentional self inflicted death, while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe

12 December 2024