CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Phillip Mitchell Boney
Hearing dates:	29 April 2024 – 1 May 2024
Date of findings:	8 August 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a First Nations man in custody - was custodial mental health care adequate – were cultural needs adequately met – was the transfer of health care information effective – have reasonable efforts been made to reduce risks associated with hanging points.
File number:	2022/264195
Representation:	Counsel Assisting the Inquest: C McGorey of Counsel i/b Solicitors NSW Coroners Court. Counsel for Senior Next of Kin Ms B Copeland: J Dougan-Jones i/b Aboriginal Legal Service. Counsel for Next of Kin Mr K Boney: Mr R Wilson of Senior Counsel i/b Hugo Law Group. NSW Commissioner for Corrective Services: P Aitkin of Counsel i/b Department of Communities and Justice Legal. Justice Health and Forensic Mental Health Network: J Harris of Counsel i/b Makison d'Apice.

Findings:	**Identity**: The person who died is Phillip Mitchell Boney. **Date of death**: Phillip Mitchell Boney died between the night of 3 September 2022 and the morning of 4 September 2022 **Place of death**: Phillip Mitchell Boney died at the John Morony Correctional Centre, Berkshire Park, NSW. **Cause of death**: Phillip Mitchell Boney died as a result of hanging. **Manner of death**: Phillip Mitchell Boney's death was an intentional self-inflicted death which occurred while he was in lawful custody.

1. Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2. These are the findings of the inquest into the death of Phillip Mitchell Boney.

Introduction

3. On 4 September 2022, Phillip Mitchell Boney aged 43 years died while he was an inmate at the John Morony Correctional Centre [the JMCC] in Western Sydney. His family has asked that in these findings he be referred to as 'Phillip'.

4. As Phillip was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody, to examine whether the State has discharged its responsibilities.

The role of the Coroner

5. 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 death.

6. In addition, 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.

Phillip's life

7. Phillip was a Gomeroi man of the Gamilaraay nation, and he deeply valued his culture. He had spent almost all his life in Moree NSW, and he had strong family and spiritual connections there.

8. Born on 27 August 2079, Phillip was the youngest of eight brothers and sisters. They are Daniel, Kevin, Charlie, Georgina, Mildred, Elton and Geraldine (who is deceased). Phillip has a daughter Bianca Copeland, and a son Gordon Copeland who tragically died in 2021. The impact on Phillip of his son's passing was profound, and this will be described later in these findings.

9. As a young boy Phillip lived in Stanley Village, Mehi Mission in the Moree area. In his early years he was raised by his grandmother Catherine Boney in Walgett. Phillip returned to Moree when he was 16 years old.

10. Phillip had a large extended family, described by his brother Kevin Boney as 'a massive mob'. On behalf of the Boney family, at the inquest Kevin paid tribute to Phillip's talent for boxing, his love for his culture, and his gift for art and drawing. Phillip's family were extremely proud that he had designed the logo for their footy team in Moree, the Mission Jets.

11. Large numbers of Phillip's family attended the inquest. They included his daughter Bianca, his brothers Kevin and Elton, his sister Geraldine, and his niece Lisa Duncan. Other nieces and nephews were also there to honour him. It was clear that they loved Phillip very much, and they put much care into honouring his memory. Some proudly wore the 'Mission Jets' jersey featuring the logo he had designed.

12. At the time of his passing Phillip had a partner, Melody Priestley. She too attended each day of the inquest, and at the close of the evidence she prepared a tribute to Phillip which was read to the court. It was clear that she and Phillip shared a close and loving relationship in his last two years. They talked by phone every day and met up in person on the rare occasions when permitted. Phillip's family felt some comfort knowing that Melody was in Phillip's life during his last hard years.

13. Bianca's love for her father was clear. She read to the court a beautiful poem which he had written for herself and Gordon. Phillip's poem beautifully conveyed his enduring love for his children and for his country.

14. I thank all these family members for their participation in Phillip's inquest. They will always mourn his loss deeply, but they sincerely seek a better future for First Nations people. Melody had this message:

> *'I really want for everyone to do better and I don't want the next person going into gaol to go through a life like that where they feel suicide is their only option … I hope Phillip's spirit can live on in some good changes'.*

15. And Phillip's brother Kevin wrote of the family's longing to see *'real and meaningful'* changes to recognise culture. He stated: '*We* really *want to be heard and listened to because we have lived this … we don't want this to keep happening to our families'*.

The issues at the inquest

16. The inquest examined the following issues:

- Were Phillip's cultural needs sufficiently considered while he was under the supervision of the Extended Supervision Order team?
- Was the mental health care which Phillip received at John Morony Correctional Centre appropriate and adequate?
- Have reasonable efforts been made by Corrective Services NSW to reduce the risks associated with hanging points in John Morony Correctional Centre?
- Should regard be had to a First Nations inmate's preference for placement with family members who are themselves in custody?
- Was there effective sharing of key information about Phillip's mental wellbeing between custodial health staff and correctional staff?

17. In preparing these findings I was greatly assisted by an Outline of Non-Contested Facts which was prepared by Counsel Assisting. At the close of the evidence the interested parties confirmed that the Outline accurately presented their understanding of the relevant facts. Therefore, I have borrowed liberally from it, in setting out the events which led up to Phillip's passing.

Phillip's earlier custodial history

18. On 27 October 2006, Phillip was convicted and sentenced for offences committed in Moree against his former partner. Following an appeal, he received a backdated sentence of imprisonment for 15 years. He was not eligible to apply for parole until 21 July 2016.

19. However, Phillip was not granted parole, and he remained in custody until his release on 15 September 2020.

20. During his time in custody, it was recorded that Phillip suffered from depression, and he carried out acts of self-harm. In one of these, recorded in 2014, he was found with a length of ripped bed sheet. Between 2014 and 2020, he was prescribed with the anti-depressant medication mirtazapine. By 2020, he was also being prescribed with quetiapine, a medication which is used to stabilise mood.

The *Crime (High Risk Offenders) Act* proceedings

21. On 31 March 2020, the State of NSW commenced proceedings against Phillip in the Supreme Court of NSW, seeking orders under the *Crime (High Risk Offenders) Act 2006* [the CHRO Act]. This Act empowers the Supreme Court of NSW to make orders for the extended supervision of a person once they are released from prison. According to the CHRO Act, community safety is to be the paramount consideration when considering such an order.

22. When the Supreme Court makes an Extended Supervision Order [ESO] under the CHRO Act, the Court will usually impose strict conditions on the person's life in the community. These can include electronic monitoring, restrictions on who they can associate with, where they can live, reporting to a Community Corrections officer, and participation in rehabilitation programs.

23. On 9 October 2020, following a hearing, the Supreme Court made Phillip subject to an ESO for a period of five years. Phillip then came under the supervision of the ESO team, a group within Corrective Services NSW [CSNSW]. He was subject to numerous conditions. To summarise, these I quote from the Outline of Non-contested Facts:

> *The ESO made for Phillip required him (non-exhaustively):*
>
> 1. *To provide a weekly plan (called a schedule of movements) (if directed to do so), such schedule to be provided 3 days before it is due to start and not deviate from that schedule without approval except in an emergency (conditions 5-7).*

2. *To live at an address approved by his Departmental Supervising Officer (DSO) (condition 9).*

3. *Not to spend the night anywhere other than his approved address without the approval of his DSO (condition 12).*

4. *Not to go to a place if his DSO tells him he cannot go there (condition 16).*

5. *Not to possess or use alcohol or illegal drugs and not possess or use prescription medication other than prescribed and submit to testing as directed by his DSO (conditions 23 and 24).*[1]

24. Phillip's conditions also prohibited him from returning to Moree without approval of the ESO team. Therefore, when he was released from prison in September 2020 he lived as directed in temporary accommodation at Parramatta, then in Campbelltown, and finally in Liverpool. Phillip did not have any family living in Liverpool.

25. It is an offence under section 12 of the CHRO not to comply with the conditions of an ESO. This offence attracts a maximum penalty of five years imprisonment and/or a maximum penalty of 500 penalty units.

26. Between April 2021 and April 2022, Phillip had some periods in custody for breaches of his ESO conditions. In April 2021, one of his drug tests returned a positive result for amphetamine and methylamphetamine. Then on 8 August 2021, he was returned to custody for a period of two months.

27. There was a further period of imprisonment between November 2021 and April 2022, for failing to comply with a condition of his ESO (refusing a request to submit to a drug test) and use of a weapon (Phillip had picked up an item in the kitchen when supervising officers attended his home).

28. On 6 July 2022, Phillip was arrested and charged with further breaches of his ESO. It was alleged that he had tested positive to amphetamine and methylamphetamine, had not attended an appointment to obtain a mental health care plan, and had deviated from his approved movements schedule. He was refused bail, and he remained in prison until his death on 4 September 2022. When he died, the above charges for breaching his ESO had yet to be resolved.

Phillip's placement at Parklea CC and JMCC

29. Over the period 8 July 2022 until his passing on 4 September 2022, Phillip was placed first at Parklea Correctional Centre (from 8 July to 5 August 2022) and then at JMCC (5 August to 4 September 2022).

30. Parklea Correctional Centre [Parklea CC] is privately managed and operated by the company MTC Broadspectrum PL. Prisoner health services are provided by St Vincent's Correctional Health [St Vincent's].

31. JMCC on the other hand is managed and operated by staff of CSNSW. Prisoner health services are provided by the Justice Health and Forensic Mental Health Network [the JH Network].

32. St Vincent's health staff at Parklea CC use the same electronic health system as do JH Network staff in prisons operated by CSNSW, known as JHeHS. The JHeHS system records and stores health information about each inmate. This includes their medical conditions and medications, notes of their consultations with health staff, and dates for appointments and reviews. St Vincent's staff and JH Network staff have shared access to this system. This is intended to ensure that when an inmate is transferred from one correctional centre to another, the health staff at the receiving centre have the same essential details of the inmate's health care.

33. In a similar way, correctional staff at Parklea CC, and correctional staff at JMCC, have shared access to an electronic system which stores information about each inmate. This system is called the Offender Integrated Management System [OIMS].

34. However, for inmate privacy reasons, there is limited access between the health electronic system and the correctional electronic system. Thus, correctional officers are generally not permitted to access information stored on the health system JHeHs. Similarly, health staff cannot generally access details stored on OIMS.

35. There are however at least two pathways which health staff can use, in order to share with correctional officers, important information about an inmate's health. One is by way of documents known as Health Problem Notification Forms [HPNFs]; and the other is through electronic health alerts. Both these sources of information are available to correctional officers and will be further described later in these findings.

The passing of Phillip's son Gordon

36. In 2021, while Phillip was living in the community but subject to the ESO referred to in paragraph 23 above, he suffered the tragedy of losing his 22-year-old son Gordon Copeland.

37. Gordon lived in Moree, like most of Phillip's close family members. In the early hours of 10 July 2021 Gordon was seen in the waters of the Gwydir River near Moree. It was dark, and the river was running fast with debris due to recent rain and flooding. Gordon was not seen alive after that night. His body was recovered three months later.

38. At an inquest into the circumstances of Gordon's death, the NSW State Coroner found that he had most likely died as a result of drowning on 10 July 2021, shortly after being sighted in the water.

39. When Gordon went missing in July 2021 Phillip sought a variation of his ESO bail, so that he could go to Moree and join the search for his son. However, his application was refused in the Local Court. Phillip was allowed to travel to Moree to attend Gordon's funeral.

40. The passing of his son grieved Phillip deeply. Phillip's niece Lisa Duncan said that Gordon had been a big part of Phillip's life, even though he had been in custody for most of Gordon's growing years. They had kept connected through phone calls and FaceTime. Phillip's daughter Bianca said there had been a special bond between her father and brother, and that she and her brother '*always knew he was our dad'.*

41. Kevin Boney wrote that when Gordon died Phillip was *'shattered'*. Elton agreed, telling police that his brother was ' … *just heartbroken, Gordon took the biggest part of him'.*

42. Phillip's partner Melody wrote that:

> *'Phillip was a happy man when I first got with him but when he found out about what happened to his son it really did change him. I noticed that he wasn't himself and that he just wasn't Phillip'.*

43. The inquest into the circumstances of Gordon's disappearance and death was held on country in Moree from the dates 18 to 29 July 2022. Phillip asked the ESO team for permission to travel to Moree for the inquest. His request was considered by the ESO team in a meeting on 26 June 2022.

44. The case notes of this meeting recorded:

> *'Discussed risks associated with granting approval for [Phillip] to attend and how it can be managed. … To be further explored should drug test return a negative result.'*

45. Ultimately however, Phillip was not given permission to attend Gordon's inquest. He had provided a saliva sample for drug testing on 29 June 2022. On 5 July 2022, the sample returned positive for amphetamine and methylamphetamine. The next day Phillip was arrested, and he returned to prison.

46. Arrangements were made at Parklea CC for Phillip to participate in Gordon's inquest by AVL. These arrangements are further described at paragraphs 56 – 59 below.

At Parklea CC: 8 July to 5 August 2022

47. On 7 July 2022, the day after he went back into custody, Phillip's health was reviewed by a nurse employed with the JH Network. During this review:

- Phillip responded '*yes'* to the questions whether he had ever tried to hurt himself, and whether he had any mental health conditions; and
- he responded '*no*' to the question whether he had ever tried to end his life.

48. The reviewing nurse noted that Phillip had numerous electronic alerts relating to self-harming behaviour, commencing in 2013. These alerts were recorded on the OIMS system and were accessible to both correctional and health officers.

49. The next day Phillip was transferred to Parklea CC. When he arrived, he received a health review by a St Vincent's nurse. The nurse recorded that:

    - Phillip had conditions of depression, high cholesterol and high blood pressure
    - in the community his health had been managed by Gandangara Medical Centre and Tharawal Medical Centre.

50. Importantly, it was also recorded that:

    - Phillip had a diagnosis of depression for which he took medication mirtazapine and quetiapine
    - he had felt depressed or down nearly every day for at least the past two weeks; and
    - he had not tried to end his life but had had thoughts of doing so in the past week and of how he might do this.

51. The reviewing nurse updated a document called a Health Problem Notification Form [HPNF]. This form is used by JH Network staff to provide brief information to correctional officers about an inmate's clinical condition. It frequently includes short form information about the inmate's mental health risks.

52. Phillip's HPNF contained an instruction to correctional officers to look out for *'fleeting thoughts of self-harm and harm to others'* and cautioned that Phillip was *'unable to guarantee his own safety'.* He was to be placed in an observation cell and be observed at least every 60 minutes. This was because during the health review Phillip had made a threat of self-harm or suicide, he had *'anxiety and depression'*, and he had '*strange behaviours, withdrawal'*.

53. On 10 July 2022 a Risk Intervention Team at Parklea CC reviewed Phillip's case and decided that he was no longer at risk of self-harm. It was recorded that he '*denies current thoughts of self harm/suicidal ideation/harming to others, denies fear for his safety, not distressed … nil acute risk of self harm/suicide'.*

54. Phillip's HPNF was then updated. It noted that he '*denies current thoughts of self harm/suicidal ideation/harming others',* but that correctional staff should look out for '*isolative behaviour, poor self care, agitation, aggression'*.

The inquest into the circumstances of Gordon's death

55. Ten days after Phillip was transferred to Parklea CC, the coronial inquest into his son Gordon's death commenced in Moree. Phillip knew that the inquest would be very distressing for him, and on 11 July 2022 he made a request to be housed with another inmate. It was stated in a case note that Phillip:

' .. was not threatening any self harm but was feeling stressed and overwhelmed returning to custody and dealing with the current inquest'.

56. At Parklea CC Phillip was permitted to view the inquest via AVL. He received emotional support from Ms Nicolle Lowe, an Aboriginal Coronial Information Support Officer with the NSW Coroner's Court. Phillip's passing only weeks later was felt deeply by Ms Lowe.

57. Among other things, Ms Lowe put correctional staff on notice that Phillip *'may need additional support throughout the inquest as it is a traumatic event for him'.*

58. Parklea CC staff did provide practical and emotional support to Phillip. Social worker Kate Pham visited him prior to and during Gordon's inquest. Together with Ms Lowe, Ms Pham helped Phillip to prepare a statement which was read to the court at the end of the evidence. Phillip's statement spoke of his joy when Gordon was born, and of the bond between Gordon and his sister Bianca. A song chosen by Phillip was also played at the inquest.

59. Towards the end of Gordon's inquest, Phillip told a staff member that '*he wanted to apply for a transfer to another correctional centre where his brother was held'.*

60. However, it does not appear that this request was taken into account when the time came to consider Phillip's next transfer.

At JMCC: 5 August to 4 September 2022

61. Phillip was transferred to JMCC on 5 August 2022, where he remained until his passing. The reason for the transfer was operational: Phillip was now classified as a remand prisoner, rather than a '*new reception'*.

62. Phillip's transfer to JMCC meant that his health care became the responsibility of the JH Network rather than St Vincent's.

63. When he arrived at JMCC, Phillip had a reception screening by a JH Network nurse. The screen noted the following:

    - a condition of depression since August 2013, for which Phillip was taking prescribed medication (quetiapine 25mg and mirtazapine 15mg)
    - that Phillip had responded 'yes' when asked if he had felt depressed or down nearly every day within the past month; and
    - that Phillip had responded '*yes*' when asked if he had thought about hurting or killing himself in the past week, and how he might do this.

64. The nurse placed Phillip on various waitlists for appointments, including ones which are specific to Aboriginal health and drug and alcohol review. He was also referred for assessment by a specialist mental health nurse.

65. Phillip's HPNF was updated to require that he be monitored for '*isolative or overly familiar behaviour, appears anxious or not coping well, withdrawn, decreased attention to self care'.*

66. Eleven days later Phillip had a review by a GP, Dr Joanne Grimsdale. Dr Grimsdale had reviewed Phillip's records from Tharawal Aboriginal Corporation and Gandangara Medical Service. She noted:

> *'Says mood low, sleeping reasonably well, appetite OK, weight stable, denies current thoughts of self harm, no psychotic symptoms. Otherwise well'.*

67. Significantly, there is no evidence that the health staff at JMCC were aware that Phillip had very recently suffered the painful experience of his son's inquest.

68. Although this important information was available to correctional staff at JMCC (it had been entered into Phillip's OIMS record), there was no reference to it in his health records. And since Phillip's transfer was for operational reasons and not clinical reasons, there was no requirement that the health teams at the two correctional centres discuss his mental health in a handover conference.

Phillip's cell placement at JMCC

69. Because of the significant impact that Gordon's inquest had on Phillip's mental health, this inquest examined what consideration was given to Phillip's cell placement when he arrived at JMCC.

70. At the time of his passing, Phillip was occupying a cell without a cell mate. It is CSNSW policy that when inmates are assessed by the JH Network to be at risk of self-harm or suicide, they should be considered for placement with another inmate. Health staff notify CSNSW staff of this by recommending on the inmate's HPNF that the inmate should be placed *'two out'*. This kind of placement is understood as a protective factor because it can reduce the opportunity for a person to attempt suicide. It can also help to ensure an early emergency response if suicide is attempted. In such cases, CSNSW staff will generally accept the recommendation, and ensure that the inmate is placed in a '*two out'* cell.

71. As I have noted, Phillip had a reception health screen at JMCC on 5 August 2022. This was described above at paragraph 63. The reception health staff concluded that Phillip did not require any specific cell placement, meaning that he was considered suitable to be placed either by himself or with another inmate. It was unlikely that the JH Network nurse who carried out this assessment was aware that Phillip had recently endured the inquest into his son's death.

72. Phillip was then placed in a cell in the Archerfield Wing. This is one of four wings at JMCC, each of which has 48 cells which can each accommodate two inmates. The cells are all identical in layout and fittings.

73. Inmates of this unit are locked in their cells from 2.45pm until 7.15am. Outside these hours they are able to move about the unit and in the yard with other inmates.

Each inmate has access to an electronic tablet which gives access to phone calls, movies and games.

74. For the following thirteen days, Phillip did not have a cell mate. Then on 17 August 2022 he was informed that a new inmate was to join him in his cell. It appears that Phillip did not welcome this news: he demanded to remain in his cell alone and threatened to assault that inmate. Because of this threat he was placed in a segregation cell. According to correctional records, officers had *'asked [Phillip] if he had a friend he would want to share a cell with, but he wants to be a one-out'.*

75. The then Governor of JMCC, Mr Brett Lees, visited Phillip the next day. Phillip told Mr Lees that he wanted to come out of segregation, which, Mr Lees agreed, was understandable as it is a very isolating environment. After their discussion Mr Lees revoked the order for segregation, and Phillip was allowed to return to the main centre population.

76. From 18 August 2022 until his passing seventeen days later, Phillip occupied a cell on his own.

77. At the time of their conversation Mr Lees was not aware that Phillip had recently undergone the trauma of his son's inquest. Mr Lees told the court that if he had been aware of this fact, he would have asked that Phillip be placed in a '*two out'* cell for a period of time, so that there would be some oversight of his welfare at this difficult time for him. If Phillip had refused to be placed with anyone else, Mr Lees would have considered placing him in an observation cell. Mr Lees acknowledged however that Phillip would probably not have welcomed being placed in such a cell.

78. In his evidence Mr Lees also that in his opinion, when Gordon's inquest was being held, the correctional staff at Parklea CC ought to have notified that Phillip was at risk for self-harm. This would have caused an updated electronic alert to be created on the OIMS system. In addition, it would probably have ensured that his HPNF was updated to recommend that he be placed in a two-out cell.

Phillip's conversation with his DSO: 22 August 2022

79. On 22 August 2022, Phillip received an AVL call from his Departmental Supervising Officer [DSO], who was part of the ESO team. The purpose was to discuss how Phillip was coping after the ordeal of his son's inquest. In hindsight, the conversation is a very significant one.

80. According to the OIMS case note of this conversation, Phillip said the inquest had been emotional for him, and that he had found it hard to '*accept how things took place'.* The DSO acknowledged to Phillip that:

> *'.. it would have been difficult for him to hear the events that took place leading up to his son's disappearance and death however that it hopefully has been able to provide him some closure and the answers to some questions he may have had …*
>
> *… [Phillip] acknowledged this and stated that now that he has the answers he was seeking, he needs to deal with his grief which will take time'.*

81. Phillip told his DSO that he felt motivated to continue with rehabilitation, but asked if he could be supported in this by a visit home to Moree. He felt that:

> *'.. being able to see his family for a week or two will assist him in staying on track and questioned if it was possible upon his release.'*

82. To this the DSO made the following response:

> *' … DSO acknowledged the importance of family and having this contact and support, however reminded him that travel to Moree, much like his request to return for the inquest, was entirely dependent on his compliance and stability and that a two week trip was highly unlikely to be approved until he can prove he can do the right thing and potentially following a shorter trip, such as a weekend with nil issues'.*

83. In submissions on behalf of Phillip's brother Kevin, Mr Wilson SC asked the court to accept that this conversation was probably of high relevance to Phillip's suicide thirteen days later. In Mr Wilson's submission, it would have been clear to Phillip from this conversation that he would be unable to return to Moree for a long time, even for a visit. I accept that this realisation was likely to have increased Phillip's feelings of despair and frustration.

The events leading up to 4 September 2022

84. Five days later, on 27 August 2022, it was Phillip's 43rd birthday. Phillip's brother Elton spoke with him on the phone. Elton thought Phillip seemed *' … very down … very down in his voice ... very unusual for him'.*

85. Phillip also his daily conversation with Melody, this time on video-link.

86. On 29 August 2022 Phillip's court matter for the alleged breaches of his ESO was adjourned to 10 October 2022.

87. Phillip had an interview on 2 September 2022 with an education officer at JMCC. He said that he was keen to start some education courses, and in particular an art class which was due to start in a few days.

88. Also, on 2 September 2022 Phillip spoke with his niece Lisa Duncan who said that Phillip *'mentioned something about home'*, but she was not sure what he meant. Afterwards she thought perhaps it was *'a sign to tell us that he's coming home, to actual home ….'.* Elton commented that this was *'the first time in his whole 16 years that he said he was coming home'.*

89. An inmate JS who was housed in the same unit as Phillip thought that he seemed withdrawn in the couple of days before his passing. He was keeping to himself and not walking in the yard as he usually did.

90. On the afternoon of 3 September 2022, Phillip made a phone call to his daughter Bianca, who said afterwards that the conversation was *'normal'*. He also made a number of phone calls to Melody, the last occurring just before the nightly cut-off time of 10.00pm. The couple had a minor argument, but they ended the call by telling each other that they loved one another. Phillip logged out of his tablet at 12.16am.

The events of 4 September 2022

91. At about 7.22am on 4 September 2022, Correctional Officer Parasdeep Bindra and inmate JS (who had work as a wing sweeper) were giving out breakfasts in Phillip's wing. They opened the door to Phillip's cell and saw a torn bedsheet around Phillip's neck. The bedsheet had been tied around a metal railing, which was fixed to the wall of his cell.

92. Correctional officer Bindra called for help, and with JS's assistance he cut the bedsheet to bring Phillip down. They placed him outside his cell door and CPR commenced. JH Network nurses arrived promptly, but it was too late to revive Phillip. He was pronounced deceased.

93. None of the inmates in the cells on either side of Phillip's cell had heard anything unusual during the previous night. Nor does it appear that Phillip had used his cell call alarm at any stage during the night.

The post-mortem report

94. Forensic pathologist Dr Sairita Maistry performed a post-mortem examination. She found the cause of Phillip's death to be in keeping with hanging. Phillip had no suspicious injuries. Toxicological analysis of his blood found there to be a therapeutic level of mirtazapine and paracetamol.

The CSNSW Serious Incident Report

95. In accordance with protocol, after Phillip's death an Investigations Team at CSNSW prepared a Serious Incident Report, dated 14 October 2022. Of interest to this inquest, the Report highlighted two matters of concern.

96. The first was the question whether Phillip ought to have been housed in a *'one out'* cell, given that he was *'an Aboriginal man with previous mental health and self harm issues who was experiencing the stress of a recent Coronial inquest into the death of his son'.*

97. On this issue, I accept that the question of appropriate cell placement can be a complex one and is very dependent on an inmate's individual circumstances. However, the inquest did highlight that certain information about Phillip's cell placement could have been better communicated between Parklea CC and JMCC. I will return to this issue later in these findings.

98. Secondly, the Report highlighted that:

> ' … *cell 47, in which Mr Boney was housed, contained an 'obvious' hanging point i.e., the frame bolted to the cell wall from which he affixed the ligature he had fabricated from bedding linen.'*

99. And further:

> *'The 'point' used to secure the ligature was a metal frame bolted to the cell wall which previously had a 'white board' affixed for use by the inmate housed there. At some point in time, the white board had been removed, probably due to damage, however the frame remained'.*

100. The Investigation Team's concern about an obvious hanging point in Phillip's cell was shared by Detective Senior Constable Luke McAlister. Detective McAlister prepared the coronial brief of evidence for Phillip's inquest. In his statement Detective McAlister concluded:

> *'I believe the death of [Phillip] was not preventable, however had the bar on the wall of the cell not been present, [Phillip] would have had limited options to use as an anchor point.'*

101. With concern, Detective McAlister noted that the same type of metal railings were also present in other cells at JMCC. He concluded:

> *' .. they should either be removed or replaced with something that would not be able to support the weight of an inmate wanting to harm themselves'.*

102. The existence of this hanging point in Phillip's cell was a very live issue at the inquest and will be shortly addressed in detail.

103. I will now examine the issues at inquest.

Were Phillip's cultural needs sufficiently considered while he was subject to the Extended Supervision Order?

104. The inquest examined whether the ESO team had given appropriate consideration to Phillip's cultural needs while he was under their supervision. The court heard evidence on this issue from Ms Ingrid Pedersen, who is Manager of the Metropolitan Extended Supervision Order Team.

105. Ms Pedersen confirmed that Phillip was supervised by an ESO team while he was in the community, up until his return to prison on 6 July 2022. She said that the ESO team is aware of the importance of cultural connection to country and community for a First Nation person living in Sydney. However, the team is also required to take into account concerns for potential victims located in the area, and any people or places posing a risk to the person themselves. I accept that this is the case.

106. Ms Pedersen observed that the ESO team had endeavoured to assist Phillip's rehabilitation, by sourcing First Nations-led community services. The Tharawal Aboriginal Corporation based in Airds had supported Phillip with accommodation, medical appointments, drug and alcohol counselling and grief counselling. He had later engaged with an additional Aboriginal health service, Gandangara.

107. Phillip was also required to undertake the Violent Offenders Treatment Program [the VOTP]. Part of this program required him to have sessions with psychologist Dr Parker, who specialises in therapy for sexual offending.

108. At the inquest, the court heard expert evidence from forensic psychiatrist Dr Danny Sullivan, about Phillip's likely mental condition both during the time he was under the ESO and then when he went into custody. Dr Sullivan is a forensic psychiatrist with extensive experience in the provision of mental health care in custodial settings.

109. Senior Counsel for Kevin Boney, Mr Wilson SC, asked Dr Sullivan if Phillip's wellbeing would have been impacted while he was subject to the ESO, as a result of knowing that for an unknown period of time he would not be allowed to return to Moree, despite his desire to re-establish his deep family and cultural connections there. Dr Sullivan thought it very likely that this knowledge would have had an impact on Phillip, as he had recently been released from a lengthy prison sentence and then found himself still effectively in detention. This likely would have led to increased feelings of distress and hopelessness.

110. Dr Sullivan agreed with Mr Wilson's further suggestion, that being required to live alone in Sydney where he did not have the support of family, friends or community would have made it more difficult for Phillip to achieve the stability he required. Dr Sullivan commented that serious consideration should have been given to finding a way to supervise Phillip on country, subject to the need for community safety.

111. Ms Pedersen was asked about this at the inquest. She agreed that the ESO team had been aware of Phillip's desire to return to Moree: he had told the team on 23 March 2021 that he wanted '*to go back to Moree with my family'.* In addition, in an interview on 14 April 2021 he had repeatedly said *'I want to live in Moree'* and '*I want to be around my family'.*

112. Ms Pedersen went on to state that it was '*a long-term plan'* for Phillip to return to Moree, but that the team's consideration of this plan was *'not well documented'.* The team wished Phillip to first progress beyond Stage 1 of the ESO. Stage 1 is the most restrictive phase and is focused on rehabilitation through working with support services. Thus, the focus for Phillip's case management had been on:

> *' … securing stable, permanent accommodation in Sydney and the management of his substance abuse issues by linking him with culturally specific alcohol and other drug service providers in Western Sydney'.*

113. Ms Pedersen agreed that in theory it would have been possible for Phillip to have lived in Moree while subject to ESO supervision. Conditions to reduce his risk to his former partner and to the community would have included electronic monitoring, and restrictions on where he could go and people he could be with. He would also have been able to access First Nations services within Moree, as well as his family. These, Ms Pedersen agreed, would have been beneficial to Phillip in his rehabilitation.

114. Mr Wilson SC asked Ms Pedersen about the importance of rehabilitation of offenders, which is an express purpose of the CHRO Act. Wasn't it the case that community safety, another key purpose of the Act, was enhanced where offenders were rehabilitated and were at less risk of offending? Ms Pedersen

agreed that this was the case, and that rehabilitation is a fundamental component of achieving community protection. These were not mutually exclusive objectives.

115. Ms Pedersen agreed further that for First Nations offenders, rehabilitation goals can be enhanced with connectedness to family, culture and community. She felt that in hindsight, the ESO team had not sufficiently understood the potential benefit to Phillip of living on country. The team had focused on helping him to achieve stability in Sydney, and '*country*' considerations had been placed second. She conceded that the negative impact upon him of being disconnected from family, community and culture had not been fully understood by the ESO team at the time.

116. Ms Pedersen told the court that Phillip's tragic passing had brought learnings to her team, about how they might manage the stringent conditions imposed by the Supreme Court in more culturally sensitive ways. She stated that the ESO team had striven to improve their understanding of culture and its impact. This understanding, she said, would now be *'at the forefront'* when considering plans for a First Nations person. The team would take as a starting point that plans to visit country should be supported unless factors excluded it from happening, rather than requiring the person to demonstrate stability before such visits could be supported.

117. The ESO team has since engaged an Aboriginal Community Engagement and Cultural Officer to engage with First Nations men under supervision, and to better ensure that country and culture are considered in team decisions.

118. Ms Pedersen also said that she would consider whether engaging a culturally appropriate psychologist might improve the VOTP; and further that she would seek permission of Phillip's family to allow the ESO team to examine these coronial proceedings as a learning opportunity.

119. These are welcome developments. I accept the submission on behalf of CSNSW, that Ms Pedersen appeared to show a genuine commitment to improving the ESO team's understanding of culture, and its importance to the rehabilitation of First Nations people under its supervision.

<u>Proposed recommendations regarding the ESO team's consideration of cultural needs</u>

120. The above evidence gave rise to further proposed recommendations, which are aimed at increasing cultural support for First Nations people who are under ESO supervision. They are:

> *That a written procedure be developed providing that those who supervise offenders under the CHRO Act should, unless it is not possible to adequately mitigate risk, supervise First Nations offenders:*
>
> - *in their own community and on country; or*

- *if that is not possible, in a community and/or country to which they have strong family and/or cultural connections; and*

- *where a First Nations offender is unable to return to country or their preferred community, maintaining their cultural connection must be incorporated into their ongoing supervision.*

121. The above proposal is an amended version of a recommendation proposed by Kevin Boney. The amended version was offered by CSNSW as one which it could support. In my view the amended version gives substantial effect to Kevin's original proposal, and I intend to make this recommendation.

> *That the Commissioner CSNSW consider requiring as part of case plan reviews (which should occur every two months):*
>
> 1. *that the ESO team consider whether its existing plan to support a First Nations person around their cultural needs remains appropriate; and*
>
> 2. *that the reasons for the conclusion reached is documented.*

122. This proposed recommendation was supported by CSNSW. It was noted in submissions on CSNSW's behalf that a cultural audit of Community Corrections policies and procedures is planned to take place in the coming 12 months.

123. Counsel Assisting proposed this further recommendation:

> *That the executive consider amending the CHRO Act to expressly:*
>
> 1. *recognise the importance of First Nations persons being reasonably supported to maintain their connection to family, community, culture and country*
>
> 2. *require consideration to be given to a First Nations person's cultural needs, and the State's plan to support the person around those needs, in the determination of the ESO application.*

124. Regarding this recommendation for legislative change, Phillip's family supported the proposal that the CHRO Act clearly express these considerations, as they were clearly relevant to the rehabilitative objects of that Act.

125. Counsel for CSNSW observed that CSNSW was not the appropriate recipient for the recommendation. However, CSNSW undertook to examine whether internal policies or procedures might need changing if this legislative amendment occurred.

126. On the basis of the evidence, I am satisfied that the above three proposals are necessary and desirable, and I intend to recommend them.

Was the mental health care which Phillip received while in custody in JMCC adequate?

127. Consultant adult psychiatrist Dr Sullivan was asked for his expert opinion on this question.

The evidence of Dr Danny Sullivan

128. Not having met Phillip, Dr Sullivan did not feel able to posthumously diagnose him with the psychiatric condition of clinical depression. However, Dr Sullivan readily acknowledged that Phillip had been suffering a heavy burden of grief and loss, in addition to the sadness and frustration he felt at being unable to change his circumstances. Phillip was also by all accounts a private person by nature, who was not in the habit of seeking comfort from fellow inmates or from counsellors.

129. In Dr Sullivan's opinion, Phillip's custodial mental health care was adequate and appropriate. Regarding Phillip's medication, Dr Sullivan noted that the post-mortem report had found there to be a therapeutic level of mirtazapine in Phillip's blood sample. This indicated to him that Phillip was being given an appropriate dosage of this medication, which he said was an effective antidepressant with the added benefit of aiding sleep.

130. Nor did Dr Sullivan consider that in the period leading up to his passing, Phillip had shown signs or symptoms which ought to have identified to prison staff that he was at risk of suicide. His phone contacts with family had not raised any particular concerns, and he had not made any disclosures to staff or fellow inmates of an intention to take his own life. Noting that Phillip was apparently by nature a private person who '*bore his grief privately',* Dr Sullivan thought Phillip was unlikely to have volunteered this information to others.

131. I accept Dr Sullivan's evidence, and the submission of Counsel Assisting, that overall, the mental health care which Phillip received while he was at JMCC was adequate.

132. However, this does not mean that his mental health care could not have been improved. Dr Sullivan raised two matters which I will examine later in these findings. These were first, that it would have been helpful if health staff at JMCC had been made aware by their Parklea CC counterparts that Phillip had recently endured the pain and distress of his son's inquest.

133. Secondly, Dr Sullivan noted that there did not appear to have been any CSNSW response to Phillip's expressed desire to be placed in a correctional centre where one of his brothers was held.

Have reasonable efforts been taken by CSNSW to reduce the risks associated with hanging points in JMCC?

134. I have mentioned that both the CSNSW investigation team and Detective McAlister highlighted a matter of significant and ongoing concern. This was the

existence of an obvious hanging point in Phillip's cell, being the exposed metal railings fixed to his wall. Not surprisingly, this was also a matter of very great concern for Phillip's family.

135. In his evidence the former Governor at JMCC, Mr Lees, agreed that if he had known of Gordon's inquest at the time that he spoke with Phillip, he would have seriously considered moving Phillip to a cell which did not contain such an obvious ligature point.

136. The inquest examined the evidence concerning this hanging point, and whether appropriate steps had been taken to remove the risk which it presented.

The evidence of Assistant Commissioner Craig Mason, CSNSW

137. Mr Craig Mason is the Assistant Commissioner responsible for Contracts and Commissioning at CSNSW. In this role Mr Mason is responsible for prison infrastructure planning and design guidelines.

138. Mr Mason was asked to give evidence on the policies relating to ligature points at JMCC and most importantly, what steps have been taken to have these removed.

139. In his evidence Mr Mason outlined the work being done on an NSW-wide basis to reduce the risk of self-harm and suicide in NSW prisons. This work includes:

- building new cells incorporating anti-ligature design principles; and
- refurbishing existing cells to remove obvious ligature points.

140. The work to remove obvious ligature points involves replacing cell doors, grills, beds, basins and tapware.

141. Mr Mason told the court that although he himself is responsible for preparing requests for cell refurbishment, the funding for this work is decided by NSW Treasury. Mr Mason went on to explain that CSNSW has a *'prioritised program'* to carry out this work. The program is based on a risk assessed basis, with priority given to correctional centres where inmates are considered to be the most vulnerable to self-harm or suicide.

142. In the 2022 and 2023 financial years, priority was given to cells at Long Bay Correctional Complex, Tamworth Correctional Centre, Parklea Correctional Centre, Silverwater Women's Correctional Centre, and the Metropolitan Remand and Reception Centre. Work was carried out in these correctional centres to remove ligature points, refurbish existing cells, and build safer new cells.

143. But the court heard there was no current schedule or timetable to refurbish any cells at JMCC. Mr Mason said this was because *'there are other accommodation cells of a higher risk priority to be completed at other CSNSW locations'.*

144. Worse still, at the inquest the court heard that the metal railings in Phillip's cell were also present in most if not all the cells at JMCC. It appears that they were originally installed so that pin boards could be attached to cell walls. In many cases however the pin boards had been removed, leaving the metal railings exposed on the wall.

145. In his evidence Mr Mason opined that there were likely to be many additional ligature points in the cells in Archerfield Unit. He maintained that for this reason, refurbishment of the cells could only take place on a 'whole cell' basis, and not in a piece-by-piece manner. There was, he said, no feasible way of removing the metal railings until planning and funding became available for wholesale refurbishment of the JMCC cells.

146. In short, almost two years after Phillip's death the metal railings remained in the cells at JMCC, and there was no current plan to remove them.

147. This evidence came as a considerable shock, especially to Phillip's family.

148. Mr Mason was questioned further on this issue by Mr Wilson SC. Mr Mason agreed that more than 80% of non-natural deaths in custody are by way of hanging, and that a key strategy in reducing this risk is the removal of obvious hanging points in cells.

149. Mr Mason was then shown photos of Phillip's cell at the time of his death, including its other fittings. These showed that at an unknown time, work had previously been done to fill in gaps at the back of the bunk beds on their step ladders. Mr Mason agreed that this work likely represented a previous effort to reduce ligature points from the bed structures. He agreed further that removing the metal railings would probably involve little more than two to three hours' work for each cell. He maintained however that it would not be feasible for the railings to be removed separately to a 'whole cell' approach.

150. It is well known that CSNSW has a policy of removing ligature points in NSW prisons, and that this work has been underway since 2016. But almost two years after Phillip used these metal railings to take his own life, the court heard that CSNSW had no plan to remove them.

151. This evidence brought shock and deep distress to Phillip's family.

152. When he gave evidence, Mr Lees too was questioned about the metal railings in JMCC cells. He agreed that they represented an obvious ligature point, and that their continuance within cells was not consistent with safe cell policy.

153. On this issue, Dr Sullivan also agreed that there is an increased risk for suicide where an inmate is in a 'one out cell' and has access to '*lethal means'*. He wished to highlight however that while reducing ligature points was very important, this work needed to be balanced with the need to maintain some degree of amenity and humanity, especially for long term detainees.

Update evidence on the hanging points

154. Three weeks after the evidence in Phillips' inquest was heard, the court received very welcome news. After hearing Mr Mason's evidence, the court had asked for further information from CSNSW as to the number of cells at JMCC which still contained metal railings fixed to the cell walls, similar to those which Phillip used.

155. In an updating statement dated 22 May 2024, Mr Jason Hodges, who is the current Governor of JMCC, advised that the metal railings and bolts had been removed from Phillip's cell. Mr Hodges said that this was as a result of Mr Lees raising the issue with him, following the evidence Mr Lees had given at Phillip's inquest.

156. Furthermore, in all other JMCC cells which had contained the exposed railings, those railings have now been removed. A number of other cells still have their pin boards in place. However, Mr Hodges advised that removal of those pin boards and railings is underway. This work is being performed on a local basis, by JMCC inmates under supervision.

157. This is very welcome news, and I commend Mr Hodges and Mr Lees for their prompt response to the evidence heard at the inquest, and the distress which it brought to Phillip's family. I hope that this response will bring some comfort to Phillip's family, as a positive step that has come out of the ordeal of his inquest.

158. This response will also enhance the safety of other JMCC inmates.

159. Without doubt however there remains a very substantial amount of work to be done in NSW correctional centres before it can be said that they are relatively safe environments for inmates. I therefore make a recommendation, proposed by Counsel Assisting, that immediate steps be taken to remove all hanging points from the JMCC, and to expedite the identification and removal of hanging points in all NSW correctional centres.

Should regard be had to a First Nation inmate's preference for placement with family members who are themselves in custody?

160. This question was prompted by certain evidence given by Dr Sullivan in his report and oral evidence.

161. I have mentioned that when he was in Parklea CC Phillip had asked to be transferred to a correctional centre where his brother was held. There was no evidence that CSNSW had considered this request.

162. In his evidence Dr Sullivan readily agreed that First Nation inmates who have a strong connection with country, family and culture can suffer strong spiritual distress if they are placed away from these connections. He expressed his broad agreement with important principles in relation to First Nations people, including that:

- social and emotional wellbeing is significantly affected by connectedness to country, family and community
- connectedness to country, family and community can be critical to rehabilitation and healing from past trauma; and
- approaches to rehabilitation need to reflect the above.

163. On this basis, Dr Sullivan proposed for consideration that when CSNSW is assessing the placement or transfer of First Nations inmates, regard should be had to their expressed preference (if any) for placement with family members who are themselves in custody.

164. At the inquest, Ms Stacey Williams (Director of Sentence Management with CSNSW) stated that CSNSW's placement regulations already provide that for First Nations inmates, there must be consideration of placing them in close proximity to family. She cited clause 20(1)(j) of the *Crimes (Administration of Sentences) Regulation 2014* [the CAS Regulation], which requires that *'proximity of the correctional centre to the inmate's family members'* be considered when a placement decision is being made.

165. The court also heard that following a recent review, the clause 20(1) factors will now apply to all inmates, where previously they had not applied to remand inmates such as Phillip had been.

166. As noted by Counsel Assisting, it is not obvious that the phrase '*proximity of the correctional centre to the inmate's family members'* captures the situation of inmates who want to be placed with family members who are themselves in custody. I accept that there should not be any ambiguity as to the scope of clause 20(1)(j).

167. It was submitted on behalf of CSNSW that this proposed recommendation was unnecessary, because according to Ms Williams, it is planned that a broader reading of the phrase *'the inmate's family members*' will be put forward in a current review of CSNSW policies and procedures.

168. But the court did not hear detailed evidence about the scope of the current review, and naturally there cannot be any certainty that this approach will be adopted and implemented following the review.

169. I therefore intend to make the following recommendation, which is supported by Phillip's family:

That consideration be given to amending cl 20(1) of the Crimes (Administration of Sentences) Regulation 2014 (NSW) to expressly require that regard be had to a preference expressed by a First Nations inmate for placement with family members who themselves are in custody.

Is there effective communication between JH Network staff and CSNSW officers regarding inmate mental health risks?

170. A final issue of importance concerned the effectiveness of information sharing between custodial health and correctional staff.

171. JH Network's Health Problem Notification Form [HPNF] is a mechanism whereby health staff are able to notify correctional officers of an inmate's specific risk factors, including mental health risks. But as pointed out by Counsel for CSNSW in closing submissions, the number of inmates and the frequency of their transfers make it difficult for correctional officers to maintain a proper knowledge of these matters.

172. This difficulty was exemplified in Phillip's case. When he was transferred from Parklea CC to JMCC, there was no clear notification to JMCC correctional and health staff that Phillip was dealing with the profound tragedy of his son's death and inquest. Although there were various references to this in the numerous records about Phillip held by CSNSW, JH Network, St Vincent's and MTC Broadspectrum, in practice it cannot be expected that in all circumstances, staff will be able to make a thorough review of an inmate's records.

173. I accept the submission that it is not an easy task to deliver key health information to correctional officers in a practical and useful manner. As expressed by Counsel Assisting in closing submissions, *'inclusion of too much information and overly generic statements*' will undermine the efficacy of information sharing systems. In addition, inmate privacy limits the sharing of all information across these organisations.

174. For this reason, Counsel Assisting highlighted the importance of ensuring that critical information is communicated clearly through the use of HPNF's and electronic alerts. The court heard that in practice, these two mechanisms are the primary means by which custodial health staff share with correctional officers' key information about an inmate's mental wellbeing. Correctional officers routinely check an inmate's HPNF and electronic alerts when making decisions about their unit and cell placement.

175. Despite this, in Phillip's case his HPNF's contained no reference to the impact upon him of the recent inquest into his son's tragic death. Nor was this mentioned in transfer forms completed by staff of St Vincent's Health. Further, the electronic alerts appearing on his CSNSW record were neither informative nor current.

176. The inquest heard evidence about these matters from Ms Shona Cuthbertson, who is the Service Director of Custodial Mental Health within the JH Network. Ms Cuthbertson told the court she would generally expect that an HPNF would contain reference to a recent tragic event in the life of an inmate. In Phillip's case this might have been a notation such as *'Recent death of a family member'.*

177. Ms Cuthbertson then advised that the JH Network is in the process of implementing an electronic version of the HPNF. It is intended that the e-HPNF will have both free text areas and a drop-down box menu, from which signs and symptoms can be selected. It is hoped that the new e-HPNF will make it possible for more meaningful information to be conveyed to correctional staff.

178. Given this, Counsel Assisting proposed a recommendation that the JH Network consider the findings in Phillip's matter as part of its project into improving HPNF practices.

179. This proposal was supported by Phillip's family, and not opposed by the JH Network. Further, although the proposal was not directly relevant to CSNSW, in closing submissions Mr Bradley advised that CSNSW are developing policies to better ensure that an inmate's current HPNF is reliably transferred to any new accommodation area they enter. And further, to ensure that the inmate's cell placement decision remains consistent with the advice within their HPNF.

180. I therefore propose to make the following recommendation:

That the JH Network consider the findings in this inquest, as part of its project into developing the new HPNF e-form.

181. Regarding the system for making electronic alerts, Counsel Assisting proposed the following recommendation:

That the JH Network, in consultation with CSNSW, review the efficacy of systems concerning electronic alerts around mental health risks that are auto populated into CSNSW's electronic system.

182. Again, Phillip's family supported this proposal. It was also supported by CSNSW.

183. Counsel for the JH Network submitted that the above recommendation was not necessary. Mr Harris wrote that NSW Health will shortly be rolling out a Single Digital Patient Record [SDPR], whereby all teams including JH Network staff will be able to access the same information about a patient. The JH Network undertook however to consider these findings in the course of the SDPR roll out, including how alerts are recorded and shared with correctional officers.

184. Despite this, I do propose to make this recommendation. The electronic alert system plays an important role in reducing inmate mental health risks. In the inquest there was no opportunity for the JH Network to provide detailed evidence as to the scope of the SDPR project, and the extent to which it would be focusing upon this particular issue.

Conclusion

185. On behalf of the coronial team, I offer sincere and respectful sympathy to Phillip's family, and I thank them for their close involvement in his inquest. I hope that the inquest brings them some measure of comfort, in knowing that Phillip's tragic passing has brought some improvements to prisoners' safety, and to the cultural wellbeing of First Nations inmates.

186. I also express my gratitude to Ms Nicolle Lowe and Ms Lizzie Jarratt, the ACISP officers at the Coroner's Court. These compassionate women provide strong and practical support to grieving First Nations families. Throughout the painful days of Phillip's inquest, they worked tirelessly to support his large family, and to keep them fully informed of what was happening.

187. I express my deep appreciation to Mr McGorey of Counsel and Ms Trinity Higgs for their excellent assistance throughout the inquest, and to the legal representatives of the interested parties for the spirit of cooperation which they demonstrated. I also thank the NSWPF Officer in Charge Detective Luke McAlister, for his very comprehensive coronial investigation.

Findings required by s81(1)

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 Phillip Mitchell Boney.

Date of death:
Phillip Mitchell Boney died between the night of 3 September 2022 and the morning of 4 September 2022

Place of death:
Phillip Mitchell Boney died at the John Morony Correctional Centre, Berkshire Park, NSW.

Cause of death:
Phillip Mitchell Boney died as a result of hanging.

Manner of death:

Phillip Mitchell Boney's death was an intentional self-inflicted death which occurred while he was in lawful custody.

Recommendations pursuant to section 82 of the Act

Recommendation 1

To the Acting Commissioner of Corrective Services NSW:

That immediate steps be taken to remove all hanging points from the John Morony Correctional Centre and to expedite as a matter of urgency, the identification and removal of hanging points in correctional centres throughout NSW.

Recommendation 2

To the Acting Commissioner of Corrective Services NSW:

That consideration be given to developing a written procedure, whereby those who supervise offenders under the *Crimes (High Risk Offenders) Act 2006* should, unless it is not possible to adequately mitigate risk, supervise First Nations offenders:

- in their own community and on country; or
- if that is not possible, in a community and/or country to which they have strong family and/or cultural connections; and
- where a First Nations offender is unable to return to country or their preferred community, maintaining their cultural connection must be incorporated into their ongoing supervision.

Recommendation 3

To the Acting Commissioner of Corrective Services NSW:

That the Acting Commissioner consider requiring as part of case plan reviews (which should occur every two months):

- that the Extended Supervision Team assess whether its existing plan to support a First Nations person around their cultural needs remains appropriate; and
- that the reasons for the conclusion reached is documented.

Recommendation 4

To the Acting Commissioner of Corrective Services NSW:

That the Acting Commissioner give consideration to the employment and/or engagement of culturally appropriate psychologists as part of the Violent Offenders Treatment Program

Recommendation 5

To the Attorney-General for NSW:

- That consideration be given to amending the *Crimes (High Risk Offenders) Act 2006* (NSW) to expressly:
    - recognise the importance of First Nations persons being reasonably supported to maintain their connection to family, community, culture and country; and
    - require consideration to be given to a First Nations person's cultural needs, and the State's plan to support the person around those needs, in the determination of an application for an Extended Supervision Order.

Recommendation 6

To the Minister for Corrections:

That consideration be given to amending clause 20(1) of the *Crimes (Administration of Sentences) Regulation 2014* (NSW) to expressly require that regard be had to a preference expressed by a First Nations inmate for placement with family members who themselves are in custody.

Recommendation 7

To the CEO, the Justice Health and Forensic Mental Health Network:

That the findings in this inquest be considered, as part of the project into developing the Health Problem Notification e-form.

Recommendation 8

To the CEO, the Justice Health and Forensic Mental Health Network:

That the JH Network, in consultation with Corrective Services NSW, review the efficacy of systems concerning electronic alerts around mental health risks that are auto populated into Corrective Services' electronic system.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner

Date 8 August 2024