STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Russell Gary Zaska
Hearing dates:	26–28 March 2024
Date of findings:	22 August 2024
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – death in custody, mental health, mentally ill person, transfer from custody to receive care, section 24 Crimes (Administration of Sentences) Act 1999, Section 86 Mental Health and Cognitive Impairment Forensic Provisions Act 2020, intentionally self-inflicted harm in custody, RIT
File number:	2020/277394

Representation:	Counsel Assisting the Coroner: Ms K Heath, instructed by Ms J Best and Ms L Carter of the Crown Solicitor's Office Justice Health and Forensic Mental Health Network: Mr J Harris, instructed by Ms A Pascoli of Makinson d'Apice Lawyers Acting Commissioner of Corrective Services NSW: Mr P Aitken, instructed by Mr V Musico and Ms S Pickard of the Department of Communities and Justice Dr Richard Baker: Mr M Hutchings, instructed by Ms J Paterson of Avant Mutual
Findings:	**Identity** The person who died was Russell Zaska. **Date of death** His date of death was between 2:15pm and 7:00pm on 23 September 2020. **Place of death** His place of death was the Metropolitan Remand and Reception Centre, Silverwater NSW 2128. **Cause of death** The cause of his death was hanging. **Manner of death** Mr Zaska died as a result of intentional self-inflicted injury while on remand at the Metropolitan Remand and Reception Centre.
Non-publication orders:	Non-publication orders made on 26 March 2024. Please contact the Registry for more details.

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Introduction and Focus of the Inquest

1. Mr Russell Zaska died in custody on 23 September 2020 when he was an inmate at the Metropolitan Remand and Reception Centre ("MRRC"). He had been held in lawful custody on remand for a period of three weeks. He exhibited a number of unusual behaviours and presented with symptoms of psychosis and so was housed in a manner designed to manage his mental health and minimise risk of harm. He was found hanging from a windowsill of his cell by a ligature made from his singlet.

2. Mr Zaska's family did not know that he was in custody at the time of his death, which added to the distress experienced when they were informed of his death.

Statutory Role of the Coroner

3. Jurisdiction is found under s 23 of the *Coroners Act 2009* to conduct this inquest because the death was a mandatory death, in that Russell died while in custody.

4. The Act requires findings to be made pursuant to s 81(1) of the *Coroners Act 2009* as to:

    a. the occurrence of the death;

    b. the identity of the deceased;

    c. the date and place of the death; and

    d. the manner and cause of the death.

5. Manner and cause of the death permits an inquiry into more than the medical cause of the death. The term "manner" includes the circumstances surrounding the death and, in this case, the actions of those responsible for Russell's care and treatment while in custody.

6. Section 82 of the *Coroners Act 2009* makes provisions for the making of recommendations considered necessary or desirable in relation to any matter connected with the death. One of the matters on which recommendations may be made is in the area of public health and safety.

7. It is not the role of the inquest to determine at law whether there has been negligence or whether damages should be paid or whether any individual is guilty of a criminal

offence. Those are matters which may be the subject of separate proceedings in other courts.

8. Given that Russell was being kept in custody and had no capacity to source treatment himself, he was reliant on the State to provide adequate medical and psychiatric care. Although the law requires an inquest into matters such as Russell's, this requirement also reflects the policy to review carefully his care and treatment, and the circumstances surrounding his death.

9. The statutory focus of this inquest is on determining manner and cause of death, making formal findings of fact and deciding whether to make recommendations. The internal review noted several events which deviated from department policies and procedures, including record keeping in respect of securing of the scene and the officers' compliance with the requirement that custodial staff whose duties involve contact with inmates be issued with and carry a 911 tool at all times. Appropriate action to sanction or remedy those breaches has already been taken by Corrective Services NSW ("CSNSW"), and so these deviations from policy were not issues that required further exploration at inquest.

Background to Mr Zaska

10. Russell was aged 33 at the time of his death. He was the son of Mr [redacted] and [redacted] and had two brothers [redacted] and [redacted]. Russell lived at the family residence in Paterson, New South Wales throughout his life but lived a more transient life following the death of his mother in 2016. Most recently he lived there with his father and his brother [redacted] He would come and go from the property, at times being absent for a few days or weeks. He had a close relationship with his aunties and uncles, and had a caring family who always looked out for him.

11. He is remembered by his family as someone with a contagious smile, with a happy and loveable nature, with a great love of adventure.

12. It is important to reflect on his life, and in particular mention those who cared deeply for him. In the latter years of his life he was significantly struggling with mental health issues, particularly after the loss of his mother. In many ways Russell's story represents so many, struggling with mental health, self-medicating with illicit

substances that would exacerbate his symptoms, coming into contact with the law all while being supported by a family who wanted nothing more than to help him.

Mental Health History

13. Much of the facts in this matter are not in dispute, and I am grateful for the observations by my instructing solicitor and submissions by Counsel Assisting from which I have drawn extensively and in relation to non-contentious issues, directly at times, in these findings.

14. Over the years Russell was supported by his family with his mental health. The last time that Russell was seen or spoken to by his father was in August 2020. His father was not aware that Russell was in custody until he was notified of his death on 23 September 2020. This was unusual because at previous times Russell would always contact his father from custody.

15. Russell has a history of mental health issues, the precise nature of which was difficult to clearly identify. The sources of information in respect of Russell's mental health issues were from his father [redacted], the Justice Health and Forensic Mental Health Network ("JHFMHN") records, the CSNSW records and the history reported by Russell to representatives from CSNSW and the JHFMHN.

16. The following matters relevant in respect of Russell's mental health history were helpfully reported by his father:

    a. Russell had always had trouble sleeping;

    b. he had been treated for depression at various hospitals;

    c. [redacted] did not believe Russell had been formally diagnosed;

    d. he would often complain of hearing voices and would disappear for weeks at a time but would always return;

    e. his behaviour had worsened since the death of his mother;

    f. [redacted] believed that Russell suffered from anxiety and always thought people were talking about him;

g. he would self-medicate with cannabis;

h. he had used “ice” in the past and had troubles with addiction but had not received treatment for that;

i. Russell was “great” most of the time but “bang he would change and be a different person”; and

j. Russell was reluctant to take prescription medication as it dulled his senses and Russell often said that he would not take medication.

17. On the last occasion that [redacted] saw Russell, he recalled Russell being upstairs at the family residence and “talking like someone was there, but there was no one there.” [redacted] reported that this was not unusual for Russell, and that Russell would become upset if his father asked who he was talking to. This speaks of the very real and complex mental health issues that Russell was coping with.

18. Russell had a criminal history dating back to 2008 for relatively minor matters, many of them traffic matters. He had documented interactions with police dating from 15 March 2007. It was reported that he regularly had adverse interactions with police during the eight years prior to his death. It appeared from police records that, as time went on, Russell was using illicit drugs and was often located in, what appeared to police, to be a state of drug induced psychosis.

19. In November 2015, Russell presented at Maitland Hospital with his mother experiencing anxiety, paranoia and describing muffled voices. He reported suicidal thoughts, with no plan formulated at that time.

20. Russell’s JHFMHN records contain material in respect of his mental health from December 2017 and early 2018, which included reports that:

a. Russell was distressed and hearing voices and noises;

b. he reported having had a disk implanted in his head when he was unconscious and had buttons on the back of his skull (and various descriptions of a similar nature);

c. he had been assessed as being at risk of self-harm/suicide when entered into custody;

d. he had a recent history of “ice” use; and

e. he was prescribed Olanzapine (10 mg).

Criminal History and Interactions with Police

21. The most recent matters that brought Russell before the Local Court of New South Wales were a series of offences, some of which were very serious. These matters were outstanding at the time of his death and were subsequently discontinued. He was being held on remand while the matters proceeded through the courts.

22. A Reception Screening Assessment conducted on 26 December 2017 included a suicide risk assessment. During the course of that assessment, Russell reported that, a “few years ago” he had tried to end his life by a shot gun in his mouth because “the voices in his hed [sic] got to [sic] much.”

23. On 4 February 2018, not long after his release into the community, Russell again presented to Maitland Hospital accompanied by his brother. He was highly anxious after using ice and experiencing mood-swings with both visual and auditory hallucinations. He was thought to be suffering a drug induced psychosis. He was not admitted to the acute mental health inpatient unit and was discharged the day after his admission with a plan for mental health follow-up.

24. On 24 May 2019, Russell was again assessed at Maitland Hospital. He was recorded to be grandiose, responding to unseen stimuli, and thought disordered. A urine drug screen confirmed recent use of amphetamines, and the clinical impression/diagnosis was of a drug-induced psychosis. He was discharged from the hospital with a plan for the local mental health team to contact him.

25. Much of Russell’s mental health history in the community was unknown to those responsible for his care while he was in custody. The relevant medical records were appropriately requested by JHFMHN staff on 9 September 2020, but for largely unexplained reasons only part of Russell’s medical records were provided.

Arrest on 1 September 2020

26. Russell was arrested on 1 September 2020 and was bail refused by police and brought before Raymond Terrace Local Court on 2 September 2020 where he was bail refused.

Movements and Interactions in Corrective Services Custody

2 September 2020

27. Records indicate that Russell was held in CSNSW custody at both Maitland Court cells and Newcastle Court cells on 2 September 2020. He was transferred to Kariong Correctional Centre on the same day.

28. A "new inmate lodgement and special instruction sheet" was completed, noting a history of mental illness, and no thoughts of suicide or self-harm. The sheet indicated that Russell had previously tried to self-harm himself and had tried to end his life previously. Each is annotated with the comment, "Long time ago, nil thoughts current." The officer also recorded that Russell could guarantee his own safety and had no thoughts of suicide or self-harm.

29. On 2 September 2020 JHFMHN Nurse Isobella Falson-King made the following relevant notations in a "Health Problem Notification Form":

    a. Previous gaol experience

    b. Denies any concerns at time if review. Nil TOSH/SI

    c. Quarantine until 16 September 2020.

4 September 2020

30. Russell was moved to the Metropolitan Remand and Reception Centre ("MRRC") on 4 September 2020. At the time of his death, he was classified as a minimum security unsentenced inmate. He was initially placed in the Fordwick unit 10, in a single cell placement.

31. Russell's intake Screening Questionnaire dated 4 September 2020 records, among other things, the following notations:

a. He denies any AOD concerns.

b. He presents calm, cooperative and accepting of his circumstances though a little zany.

c. He has a history of schizophrenia – judging by his non-committal answer he may not be up-to-date with his medication – says he is not experiencing any delusions at present but is acting a little strangely and fidgety.

d. He denies any self-harm/suicide history or ideation "since I was a kid". Emphatically repeats he has no intention to self-harm.

e. Screening call not facilitated as he has no numbers.

32. Services and Programs Officer ("SAPO") Jennifer Parslow provided a memorandum to Catherine Gibson, Manager Offender Services and Programs, stating that Russell "requested information on how to get family phone numbers" and "stated he had no self-harm/suicide issues." It is unclear when this memorandum was prepared and when it was that Russell made that request. Telephone records did not record any calls being made by Russell whilst he was in custody.

33. On 4 September 2020 JHFMHN nurse Jilane Sarjeant made the following notations in a "Health Problem Notification Form":

a. Previous custody

b. Mental Health issues

c. NCP R/V MHN (it is assumed that "NCP" refers to normal cell placement and "R/V MHN" refers to a request that Mr Zaska be reviewed by a mental health nurse.)

d. Quarantine until 18 September 2020

8 September 2020

34. On 8 September 2020 a Risk Intervention Team ("RIT") assessment was conducted, and normal cell placement recommended to Darcy 1, cell 37.

9 September 2020

35. On 9 September 2020, a mental health assessment was conducted by JHFMHN Registered Nurse (RN) Edwin Coronel. In his statement to the Inquest, RN Coronel explained that his role was to assess patients who were on the waitlist for a mental health assessment and make recommendations as to what plan of care would be most appropriate for them while they were on the waitlist.

36. RN Coronel had reviewed Russell's clinical record and was aware that he had previously been treated with Olanzapine in January 2018 while in custody, but that he was not receiving any treatment for his mental health at that time.

37. Notes made by RN Coronel on 9 September 2020 reported: "Self-reports a diagnosis of schizophrenia but giving vague details about his history and psychiatric admissions." He noted that Russell had been treated with Olanzapine (10mg) when in custody in 2018 for "DIP" [drug induced psychosis]. In relation to 2018, RN Coronel noted that "symptoms related to paranoid ideas and auditory hallucinations noted before being commenced on this treatment."

38. RN Coronel further noted that Russell had a history of admissions to John Hunter Hospital a "long time ago" and Maitland Hospital "sometime this year" but that Russell was unable to recall the reason for his admission. Russell told him he was on medication in the community but was unable to recall the name of the medication. RN Coronel reported that Russell denied recent illicit substance use but had a history of drug use and said that the last time he used was about a year ago. RN Coronel did not observe any form of thought disorder and did not consider that Russell was exhibiting symptoms related to paranoid ideas and auditory hallucinations, nor delusional ideas. However, when he asked Russell if he was experiencing symptoms related to schizophrenia, Russell replied, "Yes". When probed further, Russell said, "I don't know. It just plays up. I just need something to help me relax."

39. RN Coronel noted a "drug seeking component" during the interview. RN Coronel decided that Russell needed further assessment by a psychiatrist. RN Coronel recommended that Russell be held in Darcy in a normal cell placement until cleared by a psychiatrist, and created a waitlist entry for Russell to see a psychiatrist with a semi-urgent priority.

40. RN Coronel made the following notations in a HPNF:

    a. Previous custody

    b. Mental Health issues

    c. Cleared by Mental Health

    d. Hold in Darcy/Fordwick until cleared by Psychiatrist

    e. Normal cell placement

    f. Remain in quarantine until 18 September 2020.

41. RN Coronel requested that information be requested from Maitland and John Hunter mental health units. He obtained signed written consent from Russell to obtain his medical records from those hospitals and the form records that the information was requested on a semi-urgent basis, specified as “2 business days”.

42. JHFMHN records indicate that at least some medical records were received in response to both requests, relating to Russell’s recent admissions to hospital for physical health problems. However, for an unknown reason, the documents didn’t include any records of mental health admissions.

43. It is unclear whether these requests were sent or whether the records were followed up. What appears to be a pro-forma notation on the request forms notes “HIRS to add patient to the Primary Health waiting list if requested health information is not received within a week.”

14 September 2020

44. An incident on 14 September 2020 at 5.20pm was witnessed and reported by way of a Mandatory Notification Form (“MNF”) by FCCO Janet Blacklock. She recorded in a report of the incident that Russell was heard to be yelling at the top of his voice and most of the other inmates in the area were yelling back at him. Russell said he was “schizing out and needs to see a doctor immediately.” He was in a cell with another inmate, who was reported to be looking very concerned. FCCO Blacklock noted that Russell “appeared very mentally unwell I have placed him on a MNF as I am not

confident that he can guarantee his own safety." It was recorded that he be placed on 24-hour observation and that RIT was informed. An Immediate Support Plan ("ISP") was created by FCCO Blacklock which recommended that Russell be placed in an assessment cell and with constant electronic observations.

45. The MNF prepared by FCCO Blacklock on 14 September 2020 contained the following notations:

    a. Appears to be very mentally unwell. Claimed that he was schizophrenic during reception interview – judging from his behaviour, I believe him!

    b. Very angry, agitated, yelling, irrational

46. The other source of information about Russell's behaviour on 14 September 2020 (and the days prior) comes from Mr O'Hara, Russell's cellmate. Mr O'Hara described Russell as a "spinner" and had observed him pacing around the yard "boxing with shadows." In the days that they shared a cell, he heard Russell say things like that his "head was going to explode", that he was the terminator, that he had metal rods in his arms and metal plates in his head.

47. He described that on the day that FCCO Blacklock raised the Mandatory Notification, Russell became angry with a nurse who wouldn't give him a pill. He says in his statement:

> "[T]he war path continued for two or so hours saying all kinds of stuff. He said his dad was Donald Trump, and he could get all kinds of stuff and connections everywhere. He threatened me, saying 'If you speak about me my soldiers will take out your family.' He was just going off his head."

15 September 2020 – Review by Dr Baker

48. On 15 September 2020 Russell was seen by Dr R. Baker who noted, among other things, that Russell "presents with odd ideas and formal thought disorder. Presents with schizophrenia." A further notation was made "? Schizophrenia". Dr Baker recorded that Russell denied suicidal intent or thoughts of self-harm or harm to others. It was recommended that Russell commence Olanzapine 10 mg. It was noted: "Needs longitudinal assessment for diagnostic clarification."

49. Dr Baker's psychiatric review was not as a result of the events of 14 September 2020; rather, Russell was already on Dr Baker's list to be seen by reason of the 9 September 2020 mental health assessment by RN Coronel. The fact that Russell had been the subject of a Mandatory Notification the previous day and subject to a RIT was a coincidence.

50. Dr Baker is a psychiatrist and was seeing Russell as a treating doctor. He had no involvement with the RIT and was not engaged in cell placement determination.

51. Dr Baker had access to the JHFMHN file. He did not have access to all CSNSW documents, including documentation relating to the MNF and RIT. It is possible that there was also a verbal handover of information from the clinical nurse consultant or specialist, or from the RIT, but he did not have a recollection of that.

52. His clinical interview with Russell himself was critical. Dr Baker acknowledged that Russell was thought-disordered and a poor historian, but considered that Russell was "reasonably cooperative", had a "reasonable degree of insight" and didn't give him any reason to believe he was misleading him.

53. Dr Baker said that he was very specific in asking him directly about thoughts of self-harm or suicidal ideation. In his questioning, he was not able to elicit any indication that he had thoughts of self-harm. The overall opinion was that Russell was experiencing a psychotic episode, with symptoms including disorganised behaviour and a thought disorder. Dr Baker noted that he did not present with every symptom of psychosis. Dr Baker didn't observe any perceptual disturbances and his sensorium was intact. Dr Baker considered that he may be experiencing some delusional thought content but wasn't able to confirm that during the assessment.

54. Dr Baker formed a primary diagnosis of schizophrenia, with a differential diagnosis of drug induced psychosis. He said in evidence that the precise diagnosis would not significantly affect his assessment of risk or treatment options.

55. Dr Baker explained that severity of psychotic symptoms can be rated as mild, moderate, or severe. While he did not note his assessment of severity, the plan that he put in place for Russell however was an indication to him that he had rated his symptoms as mild to moderate in severity.

56. He considered Russell was suffering with a mental illness, with symptoms of psychosis, but Dr Baker did not assess Russell to meet the statutory test for a "mentally ill person" requiring involuntary treatment for the purposes of s 14 of the *Mental Health Act 2007*.

57. Dr Baker was satisfied that there was no risk of harm to self or others. The evaluation of risk of self-harm for a person with psychosis involved determining the existence of any nexus between any of the person's symptoms and the likelihood of self-harming. This might involve any symptoms of command hallucinations or fixed false beliefs that might lead to suicidal thinking or self-harming behaviours. Dr Baker also looked for observable signs indicative of self-harming behaviours or distress. There was nothing that caused Dr Baker to assess Russell as being at significant risk of self-harm.

58. Russell said that he was willing to take medication, and that he had successfully taken it in the past. This was an important part of the assessment process. Dr Baker explained the responsibility to provide Russell with the least restrictive care available, and given that he was willing to medicate, that was a significant factor in the decision to maintain Russell in voluntary care.

59. Although Dr Baker decided that Russell did not require involuntary treatment, he was concerned about Russell's psychotic symptoms and in his opinion, Russell required more assertive psychiatric care, and greater access to mental health nursing than was available in the main prison population.

60. On this basis, Dr Baker determined to refer Russell to the Hamden Unit. The Hamden Unit is described in the Custodial Mental Health Operations Manual as "an accommodation area for persons with severe and enduring mental illness", offering intensive outpatient treatment.

61. Dr Baker prescribed Russell with Olanzapine (10mg), an anti-psychotic. Dr Baker placed Russell on a waitlist to see a psychiatrist for follow-up review within two weeks, and a mental health nurse in one week. He also recommended metabolic monitoring of Russell given he was commencing of Olanzapine, a medication that can cause cardiometabolic side effects.

15 September 2020 – review by the RIT

62. At some time after Dr Baker's review, Russell was reviewed by the RIT.

63. RIT is a multidisciplinary team comprising of three people. Two are CSNSW staff, and one a staff member of JHFMHN. In this case, the RIT was comprised of Senior Correctional Officer (SCO) Sobhanam, SAPO Deborah Moffit, and RN Chytra-McGirr.

64. The inquest heard from each member of the RIT that assessed Russell about the role of the RIT and the decision-making process which they made in relation to Russell.

65. In accordance with usual practice, the RIT team would have had access to all the documents relating to the current RIT placement including the MNF, ISP and incident report, as well as the initial screening.

66. The JHFMHN representative, RN Chytra-McGirr, had access to JHFMHN records and was in the position to verbally inform the team of relevant information. This would have included the clinical notes prepared by Dr Baker.

67. SAPO Moffitt prepared notes relating to the interactions of the RIT team with Russell during their assessment of him. Those notes record that Russell had a history of schizophrenia and non-compliance with medication in the community and that he had poor insight in relation to his mental health and criminality. Russell reported daily cannabis use. He reported to the team that others in the pod in which he was housed were "hurting" him and that he "will defend himself."

68. It was recorded that the impression of the team was that Russell was "Disorganised with thinking, denying illicit drug use in Pod 9…mentally unstable, fluctuating mood, a bit agitated and too agreeable as has poor listening skills i.e. 'yeah I'm all good – I'm just a goer(?)…'." He was noted to be an "Unreliable historian and superficial engagement with RIT." The case notes recorded that Russell was willing to commence antipsychotic medication (Olanzapine) and noted that he was assessed as a low risk of immediate self-harm. The plan that was recorded was that the MNF be terminated, that Russell be placed in normal cell placement and referred for placement at "Hamden MH."

69. Following the RIT assessment, Russell was observed by SCO Sobhanam to be behaving strangely, jumping and laughing in his cell. This was noted to be quite different to his presentation to RIT.

70. The RIT Discharge Plan arising from the assessment on 15 September 2020 noted that Russell denied any current self-harm thoughts or "hurting others" and RIT was terminated. It noted that he was to be held in Darcy until 18 September 2020 and had been referred for "Hamden Placement". A Health Problem Notification Form dated 15 September 2020 similarly recorded that Russell was to finish his quarantine period on 18 September 2020 and be held in MRRC until he was transferred to Hamden.

Lack of contact with family

71. On 16 September 2020, Russell was seen by a SAPO at his cell door. Russell was asking about how he could contact his family, as he had no phone numbers. It was suggested that he buy a stamped envelope on buy-up and write to them.

17 September 2020

72. Russell was transferred to Darcy. Between 19 and 23 September 2020 Russell received daily Covid screening and welfare checks and it was noted that he continued to guarantee his and others' safety, and no other issues were raised. It was noted in the report that it remained unclear why Russell was not moved to the Hamden Mental Health Unit upon the conclusion of his quarantine period.

73. Russell remained in an assessment cell until 17 September 2020, and was transferred to a single cell in Darcy Unit in accordance with the plan determined by the RIT. The delay in transferring him out of an assessment cell was likely due to the unavailability of single cell availability.

74. Notwithstanding Dr Baker's referral of Russell to Hamden, the length of the waitlist for Hamden meant that Russell was not transferred prior to his death. On 16 September 2020 he was 30th on the list, and a week later on 23 September 2020 he had only progressed to position 24.

75. There is limited evidence of Russell's behaviour and mental state between 15 and 22 September 2020.

76. There were daily COVID-19 checks conducted by nurses, although these were likely of a cursory nature. Nonetheless, these did not record that Russell had any thoughts of self-harm or suicide, or other behavioural disturbances.

77. On 22 September 2020, the day before his death, Russell initiated a call on the intercom in his cell on 7 occasions. A statement from the Manager of Security of Corrective Services NSW, advised that there was a fault with the recorder, leaving no audio recording of any calls. This was extremely unfortunate, and this loss of the opportunity to explore valuable evidence could have at least provided some insight into how Russell was at that time.

Events of 23 September 2020

78. On 23 September 2020 Russell was transferred to Darcy 1, cell 62.

79. CCTV footage from 23 September 2020 recorded the following movements by Russell:

    a. At 06:15am Russell was checked by CSNSW officers. They completed a round at 06:18am and provided Russell with his breakfast.

    b. At 10:07am, Russell was allowed out of his cell. He can be seen exiting his cell and walking to the kitchen area. He then goes out of view and into the yard.

    c. At 11:32am, Russell returned from the yard into the pod. He is seen holding a towel and a red cup. At 11:33am he returned to his cell and was locked in.

    d. At 12:00pm, CSNSW Officers attend Russell's cell, unlocked the door and opened it. Russell left the cell and walked down to the chairs and tables located within the common area of the pod. He sat at the tables and Fatima Ali conducted the assessment for his Sentence Assessment Report.

    e. At 12:29pm, Russell walked back to his cell.

    f. At 12:42pm, Russell was provided with lunch in his cell.

g. At 1:34pm, Russell was checked by CSNSW officers. He can be seen putting objects into a bin outside his cell door. The door was then closed again.

80. The last reported contact with Russell before he died was at 2:15pm when an officer conducted rounds and although Russell was not seen, a verbal response was heard.

81. On 23 September 2020 at around midday, Russell was interviewed by Fatima Ali who was employed as a Community Corrections officer at the Silverwater Parole unit. She was tasked with preparing a Sentencing Assessment Report for Russell, which was ordered on 7 September 2020 by Raymond Terrace Local Court. Whilst Russell engaged in the interview and answered questions, Ms Ali observed that he "appeared to be mentally unwell and thought disordered or responding to internal stimuli".

82. He requested a chair so that he could sit in his cell and write. This request was declined by a correctional officer nearby. He voiced concerns about a television and "buy ups" in his other cell, which had not been transferred with him when he moved.

83. He was not able to confirm what mental health issues he had except that he suffered a drug induced psychosis 10 years ago, he denied suffering from hallucinations, thought disorders, anxiety, depression and responded to questions regarding his mental health with "sweet, yeah, yeah, everything is all good." Ms Ali noted that she was unable to complete a case note that day as the lights were out in the Fordwick wing. Ms Ali noted that during her interactions with Russell she had no reason to believe that he would be a risk to himself. She noted that he spoke about his family and stepchildren, agreed to do community service and engage in mental health interventions and spoke about where he intended living upon his release. He was future focused, and spoke of positive influences, she did not consider his behaviour consistent with intentions to self harm. She was confident that if she had any concerns she would have alerted the officers.

84. Ms Ali considered that he was mentally unwell, however in her experience she didn't regard him as "acutely unwell". She stated:

> "I'd say that he was quite calm and there was a very clear, in my mind, absence of distress, to me."

85. At approximately 7:25pm Russell was found deceased in his cell. Russell was found to be in a seated position, just off the floor from the cell window. Russell had a singlet wrapped around his neck. FCCO Heintz alerted the others present. He entered the cell with FCCO Leon Smith and Jennifer Udan. The singlet holding Russell to the window was cut using a 911 tool which CCO Younes said he had to run and collect. FCCOs Smith and Heintz checked for pulse and breathing. CCO Younes called for a medical response whilst FCCOs Smith and Heintz began CPR. JHFMHN nurses James Zhang and Thuy Huynh arrived soon after and took over CPR. The incident was recorded, in part, on a hand-held camera by FCCO Chee Weng Chee.

86. FCCO Heintz recalled that the ambulance arrived about 20 minutes later and took over treatment of Russell. It appears that an ambulance was called at 7:44pm. Police attended thereafter.

The Autopsy and Investigation

87. An Autopsy Report was prepared by Forensic Pathologist Sairita Maistry in which it is opined that the cause of death is in keeping with hanging. A concise summary of the report was contained in the Observations to Counsel, which I reproduce below:

    a. Full body CT scans showed rib fractures consistent with CPR, no trauma to his neck structures.

    b. Examination of the neck revealed a single ligature mark which encircled the neck and sloped upward into the occiput. The pattern and dimension of the ligature mark on the neck matched the dimensions of the singlet ligature.

    c. There were possible self-harm scars top the flexor surface of the left forearm. No other traumatic injuries were present externally.

    d. Toxicological analysis of the post-mortem blood detected a low concentration of ibuprofen and delta-9-tetrahydrocannabinol and delta-9-THC acid indicative of cannabis use. No Alcohol was detected.

88. Dr Maistry concluded in light of the circumstances surrounding the death and the external post-mortem findings that the cause of death was in keeping with hanging. In

the absence of an internal examination she was unable to fully define the presence or absence of internal pathology.

The issues

89. The issues in this matter were as follows:

1. In relation to the Risk Intervention Team ('RIT') assessment conducted on 15 September 2020:

    a. Was it appropriate for Russell to be discharged from the RIT that day?

    b. Is the current composition of the RIT being RIT Coordinator, who must be a custodial officer of Senior Correctional Officer rank or above, a JHFMHN staff member and a OS&P staff member, adequate and appropriate?

2. In relation to access and adequacy of mental health treatment at MRRC, was it:

    a. Appropriate that Russell was not prescribed medication until 15 September 2020?

    b. Considering Russell had previously been in custody and had documented mental health concerns in his custodial records, should Russell have been assessed and/or commenced medication prior to 15 September 2020?

    c. On 15 September 2020, Russell was referred to the Hamden Unit, on 23 September 2020 he remained in Darcy Pod. Should Russell have been moved to the Hamden Unit or another mental health facility?

3. Should there be any changes to the process/system in relation to inmates guaranteeing their own safety in custody?

4. Upon entering custody at MRRC on 4 September 2020, Russell was placed into a 2-week COVID-19 isolation period which was due to expire on 18 September 2020. However, he remained in COVID-19 isolation up until his death on 23

September 2020. Should Russell have been removed from COVID-19 isolation after 18 September 2020? And was any consideration given to the effects of isolation on Russell considering his mental health?

5. Upon entering custody at MRRC on 4 September 2020, Russell had no contact numbers for any family members. On 16 September 2020, Russell wanted to know how he could contact his family and was told that he could be provided with a pen, writing paper and could buy a stamped envelope at buy up. Considering that Russell had previously been in custody, that he had a history of mental health issues and that he was in COVID-19 isolation, should attempts have been made by staff to contact Russell's family?

Expert Evidence

90. The Inquest was very helpfully assisted by the reports and evidence of Dr Furst, Dr Rajan Darjee and Dr Sullivan. The experts agreed that the diagnosis of mental illness was one about reasonable minds may differ. They each provided productive and considered expert views, and the process greatly benefited from each of their experience and insight.

Appropriateness of discharge by RIT (Issue 1)

91. The RIT process is the process of determining the immediate risk of self-harm or harm to others. The members of the team are not providing mental health assessments or treatment, but rather it is a system to address immediate safety and provide the ability to take action where concerns arise.

92. While all members of the RIT considered that it was relevant to their assessment of risk of self-harm that a person was experiencing psychosis, the evidence was that they were principally concerned with whether the psychosis was related to self-harm behaviours, and whether the person was displaying self-harming behaviours or making threats of the same. Accordingly, notwithstanding that his thought disorder, mental instability and unpredictable manner were all noted, he was ultimately assessed as being a "low risk of immediate self-harm", and the RIT was discharged.

93. This conclusion was both consistent and informed by with the assessment by Dr Baker, to which the RIT had regard.

94. There was a division of opinion between the experts as to Russell's level of risk and whether there were grounds for ongoing RIT review. Dr Furst considered that, given the assessment of Russell as an unreliable historian with only superficial engagement, the RIT assessment team should have been "more circumspect" about his denial of thoughts of self-harm or suicide, and placed greater weight on objective mental state signs and behavioural observations of the deceased. Dr Furst stated:

> "I just feel quite strongly that there wasn't enough there to reassure the assessing people that things had improved or changed significantly from the previous night."

95. Dr Furst would have characterised Russell as a "moderate" risk, in part based on the uncertainty about the history being provided by Russell (who was described as an "unreliable historian"). He considered the decision to terminate RIT management was an inappropriate one.

96. Dr Sullivan, by contrast, considered that there were no specific features of Russell's presentation suggesting imminent self-harm, such that it was appropriate to terminate the RIT. Dr Sullivan noted that the assessment of suicide risk is always challenging. He explained:

> "There are many risk factors, all of which are only of weak effect size. If all people with distal risk factors – historical risk factors occurring in the past which place the person in a category of people at escalated risk of completed suicide in the future – were taken into account, prison and mental health systems would be unmanageable due to the sheer numbers of people who would be restricted to protect against future self-harm, and the uncertainty of how long to restrict them."

97. Dr Sullivan stated:

> "There's always a risk with people with mental illness but I don't think there was anything so explicit and clear that there was a clear need to maintain a particular intervention that would have prevented that…

98. In oral evidence, Dr Furst agreed that the objective signs as to Russell's mental state had been taken into account, and that his criticism came down to a matter of the weight that was afforded to different factors within the interview.

99. Each member of the RIT came and gave evidence. They were focused on the process of their role to perform in essence a safety assessment. I accept that they each were taking that role appropriately seriously, that they turned their minds to the risk factors available to them in relation to Russell, together with his presentation and made a determination based on their knowledge and observations. After it was brought to their attention that Russell's behaviour changed considerably after their final assessment, they adjusted the plan and placed him in a single cell, out of concern for another inmate who might be placed with him. They did their best in the circumstances, and there is no criticism to be made of them in performing the difficult role they were entrusted with.

Alternatives to discontinuation of the RIT

100. It was apparent from the evidence that the team considered that the role to determine was to either discharge Russell from the RIT or to maintain him in the assessment cell on the RIT. There was no consideration of a modified approach, that is to house him in a standard cell with higher levels of monitoring to continue to address concerns. The evidence on this point from Ms Moffitt was that theoretically that might be an option, but that in practice that was not done at MRRC.

101. Being held in an assessment cell involved persons being subject to harsh conditions that can impact on mental health. There is lack of privacy, observations, a lack of diversionary activities, restrictions on clothing and belongings, and the lights are kept on at night. RN Chytra-McGirr gave evidence that "they are horrific places." He explained how this factored into the decision made by the RIT:

> "Of course, if there was any concerns about risk, that over weighs that he goes into the safe cell, but if there's not that immediate pressing concern, in terms of risk to self, then you don't take that option, generally. You prefer not to. You try to avoid that."

102. In the written policies of CSNSW, "Suicide and self-harm: ISP/RIT management plan – reference guide", in force as at the date of Russell's death, is provided a table outlining minimum, medium and maximum restrictive options available to correspond with more nuanced levels of risk. This evidence does not support the position made in the notation that Russell was required to be held in an assessment cell if the RIT continued. It provides other options, such as "medium restrictive options" which could include a two-out cell with hourly visual checks through the cell door window, which could be

appropriate for “inmates who have some protective factors to balance risk factors… and whose risks can be managed with various combinations of less restrictive options”.

103. Director Wilkinson agreed with this policy, and that all of the listed options are available to a RIT team, even if they determine not to discharge the RIT. He agreed that the practice at the time of Russell’s death did not reflect that policy. He explained:

> “I think historically it was that binary assessment cell or nothing. We did increase the level of training whilst I was at the MRRC and we sort of began using the transition cells and the two-out cell placement a lot more.”

104. Russell’s is a case that may have benefited from a hybrid approach. This is not a criticism of the team, the practice I accept was somewhat all or nothing, but this is not in keeping with the policy and training and education should be promoted to ensure all options are considered.

Transition cells

105. Director Wilkinson provided evidence that, since the date of Russell’s death, MRRC had opened a dedicated block of “transition cells”. Transition cells have “reduced hanging points with fittings and fixtures designed to minimise opportunities to self-harm, and have CCTV monitoring,” but are otherwise less restrictive than assessment cells.

106. In oral evidence, Director Wilkinson described that the new Pod 22 was a 55-bed unit, with approximately half the cells being transition cells and the remainder being assessment cells. Pod 22 also has a higher level of mental health staffing.

107. Director Wilkinson considered that, if this infrastructure had been available in September 2020, it would have been most appropriate for the RIT to allocate Russell placement in a transition cell.

108. Despite this evidence, when questioned about transition cells, members of the RIT (including two still involved in RIT processes at the date of the inquest) indicated uncertainty about transition cells and their appropriate use. Consistent with the earlier submissions about the “binary thinking” by RIT members, this is indicative of an ongoing lack of appreciation of the options available to a RIT when designing a management plan to keep an inmate safe.

109. When this was suggested to Director Wilkinson, he was surprised and suggested that this indicated that further training was required. He confirmed that there was an ongoing commitment to training RIT members. Corrective Services should be encouraged to continue pursuing greater training about the use of the new facilities.

110. Pod 22 has 55 beds, not cells, and if people were required to be housed one-out the capacity would be reduced. Inmates can be referred across the State. Director Wilkinson described the bed pressure on transitional cells as being significant.

Access to and adequacy of mental health treatment at MRRC (issue 2)

Treatment prior to 15 September 2020 (issues 2(a) and 2(b))

111. There was no criticism of the screening assessment of Russell conducted on 4 September 2020 by CO Moss, and the mental health assessment conducted on 9 September 2020 by RN Coronel. On that basis I am satisfied that his assessment and the associated plans put in place for future treatment were adequate and appropriate.

Should Russell have been moved to the Hamden Unit or another mental health facility? (issue 2(c))

112. The experts agreed, along with Dr Darjee, that Russell should have been moved from the general population to the Hamden Unit. The evidence was that there was no room for Russell in the Hamden Unit. Counsel Assisting made the following observations:

> "The extensive waitlist for the Hamden Unit highlights the systemic under-resourcing of mental health care in the prison system. It is well-documented that the prison system has a substantially higher proportion of mentally ill people than in the general population, and yet access to treatments and bed is extremely limited. According to the Custodial Mental Health Operations Manual, the MHSU has 43 beds, while Hamden has 65. Referrals can come to both units from across the entire State."

113. Director Wilkinson was able to provide this information:

> "There is a bed demand meeting with Justice Health, as they control the flow of inmates in the Mental Health Screening Unit and there is a significant waitlist and it's seems to be those ones, as you said, aren't at the top end but that are still very unwell are always down the priority list, so to speak because

there's always a lot of people who are more acutely unwell, that take the spots in the Mental Health Screening"

114. Dr Sullivan indicated the following:

> "In an ideal world, all mentally ill prisoners would be transferred promptly to a psychiatric inpatient unit in a hospital, not another prison unit. Due to the lack of secure mental health beds available for prisoners, in practice, on those who pose a significant imminent risk of harm to themselves or others, or exhibit significant behaviour disturbance and require compulsory treatment, will be transferred."

115. Russell suffered as a result of the inability to provide suitable mental health accommodation for him. This raised a number of additional issues in the course of the inquest:

a. Should Russell have been assessed as a mentally ill person for the purpose of s 14 of the *Mental Health Act*, such that he was moved to a mental health facility that could provide involuntary treatment?

b. Was Hamden Unit or the MHSU the more appropriate placement for Russell?

c. Could or should Russell have been transferred to an external mental health facility outside the custodial system?

d. Was the mental health plan for Russell while he awaited transfer adequate?

<u>Was Russell a mentally ill person for the purpose of s 14 of the *Mental Health Act*?</u>

116. Section 86 of the *Mental Health Cognitive Impairment (Forensic Provisions) Act 2020* ("Forensic Provisions Act") is a specific provision for the custodial setting, which directs an inmate to be transferred to a mental health facility. The Long Bay Hospital Mental Health Unit ("LBHMHU") is a gazetted 40-bed unit that provides inpatient mental health services in the correctional system. It operates within a prison, and is the only place in NSW within a prison where a person can be involuntarily treated. The LBHMHU, like Hamden, has a waitlist, with the order of admission of patients being based on clinical need and risk.

117. Dr Baker did not consider that Russell was a mentally ill person for the purposes of s 14 of the *Mental Health Act*.

118. Dr Furst was of the view that there were grounds for finding that Russell was mentally ill. He agreed that the statutory test was broad and required a degree of interpretation by the doctor.

119. Dr Sullivan was not of the view that Russell would have satisfied the criteria to become an involuntary patient on the basis that he did not meet the threshold for behavioural disturbance. Dr Darjee agreed with Dr Baker's conclusion that involuntary treatment was not required.

120. The experts agreed that minds could differ on this point. I accepted that Dr Baker had the advantage of the interaction with Russell. The account of his assessment of Russell was impressive. He was careful and considered, and turned his mind to the options available and his responsibility pursuant to the *Mental Health Act*. He was satisfied that Russell would self medicate and on that basis did not consider him mentally ill pursuant to section 14. He did take the additional step of determining that Russell did require additional care, and as such waitlisted him for Hamden, and required a further assessment of him.

Was Hamden Unit or MHSU the more appropriate unit for Russell?

121. The Hamden Unit is described in the Custodial Mental Health Operations Manual as "an accommodation area for persons with severe and enduring mental illness," offering intensive outpatient treatment. The MHSU is another location within correctives where specialist resourcing provides assertive mental health care, operating as a quasi-inpatient unit. On the evidence it provides more comprehensive mental health care than Hamden. However neither are declared mental health facilities for the purposes of the *Mental Health Act 2007*, so therefore involuntary treatment cannot occur in either.

122. Dr Furst's assessment was that Russell was acutely unwell, and the recommendation for placement in Hamden was inadequate. In his opinion MHSU should have been recommended for Russell. Dr Furst's concern was supported by the evidence of SAPO Moffitt:

> "I think you think maybe if they get to Hamden straight away that there's just going to be this automatic care for them, which isn't the case. Hamden is just part of the gaol with some doctors and mental health nurses."

123. Dr Baker referred Russell to Hamden rather than MHSU after he considered the acuity of his symptoms, his risk profile, and the fact that he was compliant with medication. In his view those needs could be met in Hamden. He also took the approach from the perspective of least restrictive care. Both referrals kept Russell by necessity in a maximum security setting. MHSU had even more restrictions inherent in that placement. Director Wilkinson said that MHSU had limited programs and services provided by SAPO's with Corrective Services, less facilities including limited access to program rooms, computer rooms, open-air yard, and recreation hall and other activity yards. Director Wilkinson, in his evidence, confirmed that the Hamden Unit would be considered the less restrictive form of care.

124. Dr Baker was also mindful of the fact that the reality was that Russell would be unlikely obtain a bed in MHSU with his presentation. A person would usually get a bed in the Hamden Unit faster than MHSU. This observation was supported by the evidence including that of SAPO Moffitt said it was "very rare" to get someone into MHSU, and even if you were referred, "you may never get there." Director Wilkinson confirmed that MHSU had the longer waitlist "by a significant amount." He said, "There's a lot of bed pressure. They're in high demand, those beds."

125. Had Russell been referred to MHSU, he likely would have been continually waitlisted as a result of the continuous presentation of more serious presentations. Dr Baker himself expressed, "decision-making happens within the context of the known resources available." Dr Baker was also factoring in the reality of the prison environment and limitations, and attempted to get the best outcome for Russell in those circumstances.

126. Dr Baker provided appropriate care to Russell. He considered the options, made a diagnosis, assessed him according to his clinical presentations and gave a direction to attempt to get for Russell suitable care. Although the expert opinion may have differed at times with his determination, there was no suggestion on the evidence that the diagnosis and proposed treatment plan was not open and available to Dr Baker to make. I accept that Dr Furst's opinion as to the acuity and severity of Russell's symptoms were at a higher category than Dr Baker found. I accept there is a range of reasonable diagnostic findings by a psychiatrist in treating a patient. I accept that

minds will differ, and that Dr Furst would have categorised Russel differently, and have treated him more urgently.

127. Dr Furst gave evidence from the viewpoint of general best practice. His evidence was transcending the limitations imposed in a prison, and he was looking from the perspective of what Russell should have received if he was available in the community. It is true that the community has its financial and service provision restriction in the community. However, those in custody are often at the upper limits of mentally unwell people in our community. They are often in custody because they already have, or been alleged to have, compromised community safety, sometimes very significantly and at great cost to individuals.

128. Dr Furst was promoting the concept of appropriate treatment for the illness. He gave very powerful evidence relating to the JHFMHN's practice of not using s 24 of the *Crimes (Administration of Sentences) Act 1999* to facilitate the treatment of psychiatric illnesses. Section 24 states:

> 24 Transfers to hospital
> (1) The Commissioner may order that an inmate be transferred--
>
> (a) to a hospital (including a hospital that is or forms part of a correctional centre or correctional complex), or
>
> (b) to some other place specified in the order,
>
> if of the opinion that it is necessary or desirable for the inmate to receive medical attention there.
>
> (2) While the inmate is at the hospital or other place, the Commissioner may direct a correctional officer to take charge of the inmate.
>
> (3) An inmate who is transferred to a hospital may be discharged from the hospital on the certificate of the medical superintendent or other person in charge of the hospital.
>
> (4) On being discharged from the hospital or other place, the inmate must immediately be returned--
>
> (a) to the correctional centre from which the inmate was transferred, or
>
> (b) to such other correctional centre as the Commissioner may direct.
>
> (5) The Commissioner's functions under this section may be exercised in relation to a correctional centre by the governor of the correctional centre.

129. He supported the proposition that if the appropriate care could not be immediately or reasonably quickly provided to an inmate, the inmate ought be removed and placed in a hospital environment that would provide the opportunity for the appropriate care. He noted the distinction that is drawn between physical and mental health conditions. This was a distinction that Dr Furst was highly critical of in his evidence, stating:

> "I wouldn't have to sit in the coroner's inquiry and ask for someone to be admitted to a cardiac intensive care unit for the heart attack, because everyone knows they need that, but I have to sit here and talk about someone who's psychotic needing hospital for a psychosis."

130. This evidence was highly persuasive and compelling. The evidence establishes that more assertive mental health treatment for inmates within the prison system is constrained by the limited number of beds available within LBHMHU and other specialist mental health facilities, this is despite the knowledge that a highly disproportionate number of inmates suffer from mental illness compared to the general population. Given the high proportion of mentally ill persons in custody, this raises real concerns that mentally ill persons are not being provided with the care that they require in a timely manner.

131. Dr Baker gave evidence that, in the community, it would be a reasonable assumption that a person who was found to require involuntary treatment would have access to a bed reasonably quickly, usually within 12 hours. This is not the case necessarily in custody.

132. I note that Dr Baker established in evidence that it was open to him to find that Russell was not mentally ill pursuant to the Act. However, he also appropriately found that Russell was suffering from a mental illness and at minimum required the additional attention of doctors and nurses in the Hamden Unit. He also was acting in a way consistent with the resources available at the time, and noted that the reality was that Russell was far more likely to get into the Hamden unit than the MHSU. It was clear from his evidence that this thinking did affect the placement he recommended for Russell. In essence he was working to get the best outcome for Russell working within the constraints of the prison environment.

133. Given the historic lack of utilisation of s 24 to transfer psychiatrically unwell inmates, it is likely that that option was never considered for Russell. The question was not explored with Dr Baker, being an issue that arose later in the inquest. There is no doubt that this has been a practice in the custodial setting for many years, and there is no criticism of Dr Baker in any way in relation to consideration of a s 24 transfer.

134. I accept that in Russell's case, Dr Baker's assessment may have inevitably had the result that a s 24 transfer would not have been recommended even if considered an available option. Similarly, if a medical officer at an external officer reached the same view as Dr Baker, that involuntary treatment was not required, he may not have been admitted to an external mental health unit.

135. There is no finding that the s 24 mechanism ought to have been used in Russell's case. However, Dr Furst's opinion was very compelling. An often-ignored factor is the pain and suffering, and higher risk placed on those with identified mental illness, in particular psychotic symptom, when they are locked in a cell, with limited interaction, treatment, observation and medical care. This would not be found acceptable in a mental facility or unit, and yet somehow this is tolerated in cases such as Russell's.

136. Submissions were made that section 86 of the *Mental Health Cognitive Impairment and Forensic Provisions Act* is the appropriate mechanism for transfer to a mental health facility, to the exclusion of the operation of section 24 of the *Crimes (Administration of Sentences) Act 1999*. In my view these two Acts are proposing two different mechanisms. One relates to the Secretary, one relates to the Commissioner. One reflects a desire to place an inmate in high level mental health care, the other can be used for various purposes related to mental health, including treatment, medication, diagnosis, immediate safety, and addressing basic human rights when they cannot be met in the custodial setting. This should not be a matter that falls outside consideration, and remains a valid mechanism for transfer to hospital in appropriate cases.

137. The continued distinction between urgent psychological care as opposed to physical emergencies in the custodial setting is not in keeping with today's medical understanding of the physicality of illnesses of the mind.

<u>Mental health plan while Russell awaited transfer to Hamden</u>

138. Dr Baker was a careful treating psychiatrist and had Russell's best interests in the forefront of his mind. He was working within the limitations of the custodial setting. All expert witnesses agreed that this management plan was adequate and appropriate.

Whether Russell's death was precipitated by his mental illness

139. Prior to considering this issue, a relevant fact is to consider the effect of the illness on the death of Russell. This has obvious implications when looking at the treatment Russell received while in custody. The three experts gave evidence about the treatment Russell received, including his diagnosis and mental illness status pursuant to section 14 of the *Mental Health Act*.

140. It was recognised that Russell had a past history of treatment with antipsychotic medication, but he did not have an established mental health diagnosis. Dr Baker had, on the information available to him, made a provisional diagnosis of schizophrenic but thought longitudinal assessment was needed for diagnostic clarification.

141. On review of Russell's full medical history, the expert witnesses agreed that Russell's medical records were consistent with:

    a. A primary clinical diagnosis of methamphetamine dependence; and

    b. Intermittent and recurrent episodes of drug induced psychosis (a substance-induced mental disorder), with a primary differential diagnosis of an emerging schizophrenic illness.

142. To determine between a drug-induced psychosis and schizophrenia would have required continued monitoring and assessment of Russell's symptoms, to observe whether his symptoms persisted for many months despite abstinence from methamphetamine abuse.

143. In September 2020, the observations of Russell indicated that he was experiencing a further psychotic episode. While Russell was not subject to a further psychiatric assessment following 15 September 2020, all experts agreed that any psychosis would likely have been ongoing as at the time of his death, although also noted that his mental state may have been fluctuating.

144. Dr Furst was of the view that given the persistent psychotic symptoms it was highly likely that Russell's suicide was the product of the psychotic episode he was suffering as at 23 September 2020. He supported this conclusion by reference to the elevated risk of suicide for people with a mental illness during an acute episode of psychosis, explaining in his report that:

> "People who are acutely psychotic lose touch with reality and often react to delusional, thoughts and/or hallucinations of a commanding nature, often killing themselves without warning when minded to do so…"

145. Dr Sullivan and Dr Darjee considered that Russell's death was associated with his mental illness, however they were unable to draw a firm causal connection.

146. On the basis of the opinions provided, it is sufficient in my view to find that his death was closely linked with his mental illness.

The process of inmates guaranteeing their own safety (issue 3)

147. In his expert report, Dr Furst observed that clinicians assessing statements of Russell were required to be circumspect about the statements made by Russell concerning his thoughts of self-harm or suicidal intention, particularly given the objective indications that he was an unreliable historian and suffering from thought disorder. Dr Furst emphasised the importance of relying on objective indicators rather than only an inmate's self-report.

148. In Russell's case, having heard evidence from Dr Baker, the Court could be satisfied that Dr Baker was circumspect and cautious as he assessed Russell, but that those inquiries did not reveal any specific self-harm risks at that time, beyond the risk associated with his psychosis.

149. Dr Baker was an experienced and considered psychiatrist. He indicated an appreciation of the fact that a person may not remember, or may not wish to disclose, certain aspects of his history. He described various interviewing techniques that could be used to try and probe for thoughts of self-harm, such as asking multiple times in different ways, and using techniques to "normalise" and reduce defensiveness around articulating thoughts of self-harm. He took into account objective indicators of Russell's behaviour in forming his clinical assessment.

150. In oral evidence, Dr Sullivan observed that:

> "It's common that prisoners are telling you things or not telling you things… Unreliability or inconsistency of histories is a pretty common finding. So I think that what you're left with is clinicians having to make reasonable inquiries about a person's mental state, ask explicit questions and look for behaviours which suggest a risk of self-harm that may be more imminent than not…"

151. Dr Darjee did opine, in oral evidence, that Russell's suicidal ideation may have arisen only shortly before his death. In that case, "no matter how good your probing was, you're not going to pick up evidence of suicidal ideation because there wasn't any".

152. I cannot make a finding as to when Russell's suicidality presented with any degree of certainty. I accept Ms Ali made proper observations of Russell, and that she would have taken steps if she had held concerns. It seems there was a sudden decline in his mental state after this time. There was no evidence that any staff member or medical practitioner had warning.

The decision to place Russell "one-out" (Issue 4)

153. The decision to place Russell "one-out" followed observations made of his behaviour in the assessment cell, including "jumping around" and "shadow boxing", and was motivated by not only a risk that Russell posed to the safety of others, but also a concern for Russell's safety from others who might react badly to his strange behaviours.

154. Due to the COVID-19 pandemic, the decision to place Russell one-out meant that his interaction with other inmates was limited to his one-hour of yard time. However, there was evidence that many inmates preferred being placed one-out, as it granted them greater control and privacy.

155. Dr Sullivan stated that a single-cell was correlated with completed suicide attempts, but the correlation was only weak. Dr Furst similarly gave evidence that there was not good evidence to support the proposition that two-out placements play a significant role in decreasing the risk of suicide.

156. I am satisfied that the RIT acted appropriately in the circumstances.

Lack of efforts to facilitate contact with family (Issue 5)

157. There has been a great sadness experienced by Russell's family over the significant lost opportunity to protect Russell's mental health given with the lack of effort by CSNSW staff to assist Russell in contacting his family.

158. The information obtained by CSNSW staff in the intake screening of Russell was that he had been living with his father prior to his arrest and that his family were a significant source of support for him. He told officers that his father "helps [him] out with everything." When asked, "What support will you have while you are in custody", Russell had answered "family".

159. At intake screening that he did not have any phone numbers for his family, so a call was not facilitated. Director Wilkinson agreed that it would have been best practice for an officer to explore the issue further with them, although it is noted that Russell reportedly told officers that "he will be fine as he is confident he will be released at court on Monday".

160. On 16 September 2020 he self-referred to a SAPO, wanting to know how he could contact his family as he had no numbers. This was only a day after he had been discharged by the RIT, and I agree with the submissions that there should have been at least some awareness of his potential vulnerability and poor mental health. It was suggested to Russell that he buy a stamped envelope on buy-up and write to them. This is very unsatisfactory evidence to the approach of a person suffering from significant mental health issues.

161. This response was inadequate. SAPO Moffitt explained that a lack of numbers was a common problem, and that there were strategies that could be used to assist in finding numbers. She stated:

> "If he doesn't know a number most of our staff will try their utmost to obtain a number. We can ask some questions like, well, you know, is your brother-in-law a tradie, does your girlfriend work at a hotel. Like, I have rung pubs before where, you know, family members are present there, just to try and contact someone. So every measure will – every effort will be taken to try and contact someone."

162. Another solution as submitted may have been to look up his contacts from previous periods in custody, which records are easily available and can be accessed without restriction.

163. It was accepted by CSNSW that this was a failure of process and Director Wilkinson gave evidence that it was best practice for a call to be made to family at the reception process, or at least for an alert to be entered on the system to make a priority referral to a SAPO.

164. At a minimum, Russell should have been advised of the policy to allow two letters per week at the expense of Corrective Services if an inmate did not have buy-up money. He should have received a helpful and humane assistance in his circumstances. The value of family cannot be underestimated, especially with such vulnerability.

165. An opportunity was missed to provide Russell with extra support and a significant protective factor, a proposition with which Director Wilkinson agreed.

Submissions

166. As set out in submissions on behalf of JHFMHN, I accept that no individual practitioner or staff member is the subject of any criticism. To the contrary, Dr Baker was careful and considered in his approach, and his ultimate decision was a decision based on his clinical findings and was open to him to make. Equally RN Coronel treated Russell with care and made appropriate recommendations for his care.

167. The RIT Team's decision was open to them in the circumstances, and the value of their evidence was to indicate that as a matter of general practice, hybrid options were not generally used to maintain a RIT in less restrictive accommodation. That may be an issue that can be explored now that it has been identified.

168. I also note the submissions in relation to s 24 of the *Crimes (Administration of Sentences) Act 1999*, and I accept that the position would remain that a determination by the relevant hospital would be required in relation to mental health treatment, and where an inmate presented that Hospital would be required to make a determination pursuant to the *Mental Health Act* as to whether or not they would be ultimately detained.

169. It was accepted that available resources in gaol do not meet the psychiatric needs of all patients in gaol. Mental health resources are scarce. It is in those circumstances that JHFMHN operates, and staff must allocate bed places according to the acuity of patients. Further I accept the submission that any prisoner with necessary mental health needs should be treated in a therapeutic environment. Ideally any person who is a mentally ill person should be transferred promptly to inpatient unit in a hospital.

170. Further, I am assisted by the fact that JHFMHN is a statutory corporation pursuant to s 41 and Sch 2 of the *Health Services Act 1997*. It does not determine its own resources, that is a matter for the Minister. JHFMHN continues to advocate for further resources to be provided in the area of mental health, and Russell's case is further support for this.

171. In relation to the submissions by the Acting Commissioner of CSNSW, it is submitted that in relation to s 24 of the *Crimes (Administration of Sentences) Act 1999* that there are limitations to this approach, including the practicality of CSNSW officers being armed, causing distress to other patients, CSNSW being required to maintain the safe custody of inmates, and may include the using of handcuffs which may be clinically inappropriate for forensic patients and additional resourcing burden on the state for additional supervision staff.

172. The submissions also raise that section 86 of the *Mental Health (Cognitive Impairment and Forensic Provisions) Act* provides a mechanism for the transfer of inmates from a correctional facility. It is submitted that s 86 provides the appropriate mechanism for the compulsory transfer of inmates to a declared mental health facility with appropriate safeguards that are not available under the CAS Act. Section 86 provides:

> **86 Transfer from correctional centre or detention centre by Secretary**
>
> (1) The Secretary may, by order in writing, direct that a person imprisoned in, or a forensic patient detained in, a correctional centre or detention centre be transferred to a mental health facility.
>
> (2) The Secretary may make a transfer order on the basis of 2 certificates about the person's condition issued by 2 medical practitioners, 1 of whom is a psychiatrist.
>
> (3) The certificates are to be in the form set out in Schedule 1.

(4) A transfer order may be made without the person's consent if it appears to the Secretary, on the basis of the certificates, that the person is a mentally ill person.

(5) A transfer order may be made with the person's consent if it appears to the Secretary, on the basis of the certificates, that the person has a mental health impairment or other condition for which treatment is available in a mental health facility.

(6) The Secretary may revoke a transfer order.

(7) The Secretary must notify the Tribunal in writing if the Secretary makes or revokes a transfer order

173. It is of note that the provision in s 24 and the provision in s 86 differ in who may make the order and where that person is directed to be transferred to.

174. The evidence of Dr Furst is support for the proposition that where that is not available, there is no impediment in this specific case for the utilisation of s 24 to provide appropriate and reasonable care within a reasonable time frame to an inmate who requires medical care. He highlighted the need for mental health to be treated in a consistent fashion, in appropriate cases, with a physical emergency. The evidence of Mr Wilkinson was that he saw no impediment, however on the facts of this case I do not need to make a determinative finding on that issue, other than to say that in neither submission is it proposed that s 24 is unavailable, but instead, that s 86 would be the preferable mechanism.

175. In relation to the submissions on behalf of Dr Baker, I accept that Dr Baker's management plan was in all of the circumstances appropriately directed to delivering care to Russell. The decision of when and where to move Russell was within Dr Baker's control or power. He factored in the limitations and put the best interests of Russell first in trying to get the best outcome for him.

Conclusion

176. The inquest into Russell's death highlighted the reality of long wait times for specialist mental health units within the prison. These wait times lead to delays for inmates like Russell to receive the level of mental health support that a psychiatrist has

recommended. Inadequate mental health resourcing in the prison environment continues to cause unnecessary suffering by those with mental illness and undermines policy goals such as rehabilitation and reduction of recidivism.

177. While no specific recommendations arise from this lack of resourcing, CSNSW and JHFMHN should continue to seek resources to address this scarcity, and the Court's findings in Russell's death may contribute to that effort.

178. The findings may also prompt consideration of the use of s 24 transfers for the treatment of psychiatric illnesses for those inmates where the recommended level of care cannot be provided.

Acknowledgments

179. Thank you to the Counsel and solicitors acting for the sufficient interest parties for bringing a productive and helpful approach to this matter.

180. To the officer in charge for assisting in the gathering of important evidence and time set aside to prepare the brief.

181. To Counsel Assisting Ms Heath and Ms Best and Ms Carter and those at the Crown Solicitors, for the careful preparation, presentation and summary of the relevant facts and issues.

FINDINGS REQUIRED BY SECTION 81(1)

Identity

The person who died was Russell Zaska.

Date of death

His date of death was between 2:15pm and 7:00pm on 23 September 2020.

Place of death

His place of death was the Metropolitan Remand and Reception Centre, Silverwater NSW 2128.

Cause of death

The cause of his death was hanging.

Manner of death

Mr Zaska died as a result of intentional self-inflicted injury while on remand held in lawful custody at the Metropolitan Remand and Reception Centre.

I extend my most sincere condolences to the family of Russell.

I now close this inquest.