**STATE CORONER'S COURT**

**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Simon Cartwright |
| **Hearing dates:** | 20-24 May 2024; 19-20 August 2024 |
| **Date of findings:** | 3 December 2024 |
| **Place of findings:** | Coroners Court of NSW, Lidcombe |
| **Findings of:** | Deputy State Coroner, Magistrate Erin Kennedy |
| **Catchwords:** | CORONIAL LAW – Correctional inmate, failure to observe signs of illness, failure to diagnose, peptic ulcer, natural causes, failure to identify illness, need to deliver treatment, involuntary detained inmate, waitlist for appropriate mental health facility, mental health treatment, 24 hour surveillance cell, RIT, observation cell, mentally ill person, Section 24, Crimes (Administration of Sentences) Act 1999, 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* |
| **File number:** | 2021/00268412 |
| **Representation:** | Counsel Assisting the Coroner: Ms K Heath and Mr M Robinson, instructed by Ms I Pearson of the Crown Solicitor's Office<br><br>Justice Health and Forensic Mental Health Network: Mr J Harris, instructed by Mr B Ferguson of Hicksons Lawyers<br><br>Commissioner of Corrective Services NSW: Ms A Avery-Williams, instructed by Ms J Holmes of DCJ Legal<br><br>Mr G Panuccio: Mr A Howell, instructed by Mr M Burns of McNally Jones Staff Lawyers |

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| **Findings:** | **Identity**<br><br>The person who died was Simon Mark Cartwright.<br><br>**Date of death**<br><br>Simon died on 19 September 2021 sometime between 8.05 am and 7.30 pm.<br><br>**Place of death**<br><br>The location of his death was the Darcy 1 Pod within the Metropolitan Remand and Reception Centre in Silverwater, New South Wales.<br><br>**Cause of death**<br><br>The cause of his death was septicaemia secondary to chronic peptic ulcer disease.<br><br>**Manner of death**<br><br>Simon died as a result of undetected treatable natural causes while involuntarily detained as a mentally ill person within the general prison population while waiting 17 days for a bed in a mental health facility. |
| **Recommendations:** | **To Justice Health and Forensic Mental Health:**<br><br>1. That Justice Health consider a review of policies or procedures for monitoring the food and/or fluid intake of an inmate, with a view to ensuring that food and/or fluid monitoring is undertaken if recommended by a doctor.<br><br>2. That Justice Health consider investigating options for:<br><br>a. employing psychologists to provide therapeutic services to inmates; and<br><br>b. creating systematic support for people with personality disorders in custody.<br><br>3. That Justice Health give consideration to recommending a medical transfer of psychiatrically ill patients to external hospitals pursuant to s 24 of the *Crimes (Administration of Sentences) Act 1999* in circumstances where no beds are available for a transfer pursuant to s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.<br><br>**To the Commissioner of Corrective Services:** |

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| | 4. That Corrective Services consider the implementation of a formal policy that addresses:<br>a. the responsibilities of corrective services officers to ensure access to water;<br>b. the circumstances in which water to an inmate's cell can be turned off;<br>c. the procedures to be followed if the water to an inmate's cell is to be turned off;<br>d. the measures that must be taken to ensure than an inmate has sufficient access to water for drinking and hygiene if their water is turned off; and<br>e. requirements for maintaining records in relation to the same.<br>5. That Corrective Services give consideration to taking steps to ensure adherence with COPP 1.4, subsection 3.4, that requires approval of the governor if an inmate's placement in an Assessment Cell exceeded 48 hours.<br>6. That Corrective Services give consideration to mandating Mental Health First Aid training for officers who are assigned to supervising inmates in observation cells and/or on RIT management.<br>7. That Corrective Services give consideration to the development of a system that ensures all of those officers who are assigned to supervising inmates in observations cells and/or RIT management are made aware at the start of each shift of the reason why each inmate has been placed in those cells.<br>**To both the Commissioner of Corrective Services and Justice Health and Forensic Mental Health:**<br>8. That Corrective Services consider the production of a memorandum outlining what level of service is provided by Corrective Services Staff of an inmate placed in an observation cell (including the 24-hour surveillance cell), to clearly identify and communicate what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and |

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| | how regularly it will be staffed and viewed, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for consideration of circulation to medical staff to allow development and management of treatment plans. |

**Contents**

## INTRODUCTION AND FOCUS OF THE INQUEST

1. This is the inquest into the death of Simon Cartwright. In accordance with the wishes of his family, I will refer to Mr Cartwright by his first name, Simon throughout these findings.

2. Simon Cartwright was just 41 when he died from septicaemia, septic shock which was secondary to chronic peptic ulcer disease. Simon died in plain sight, as a result of a treatable underlying condition. He was being held in custody on remand in an observation cell for almost one month prior to his death. He was on a RIT for that time. He was diagnosed as a mentally ill person pursuant to the Mental Health Act 2007 for 17 of those days, of which he remained in a custodial setting and was not transferred to a mental health facility.

3. His overall behaviour was erratic, unpleasant, disordered and troubled, he was diagnosed in custody with schizoaffective disorder, bipolar type presenting with elevated mood, disorganised behaviour, and persecutory delusions in the context of medication discontinuation.

4. In the last days of his life, he had been placed in a 24 hour CCTV surveillance cell.

5. He was suffering with serious symptoms from his mental health, and was unable to communicate well with those around him. The correctional officers tasked with his day-to-day care did not appear to know or understand that he was a mentally ill person requiring hospitalisation.

6. During his final days his access to water was removed from his cell after the water was turned off in his cell because he flooded it, and it was not reinstated. He did not and perhaps could not articulate his symptoms, however he did have a significant number of distressing sudden unexplained falls, he was extremely thin to the point of emaciation, and appeared at times to be doubled over in pain. He shuffled along like a much older individual as he walked in the facility, at times bent over, sometimes he protectively hugged his stomach. At other times he sat with his head in his hands. He peppered the knock up system with calls for help in the nature of requesting food and calling for his water to be reinstated. These

were calls from a mentally ill person, that at the time were misunderstood by custodial staff, and as a result he did not receive attention nor assistance.

7. The camera surveillance, and recorded calls or “knock ups” to Correctives Staff provided important objective evidence of the last days of Simon’s life. This evidence was harrowing and distressing for all watching it.

8. Although in ostensibly a 24 hour surveillance cell, he was in fact not being observed, nor indeed observable, 24 hours a day. The camera was covered by him sometimes and therefore not able to be viewed at all times. In the days leading up to his death no one identified that Simon was in fact in urgent need of medical attention. His falls were not observed, his weakened state was not investigated. The seriousness and urgency of his condition was missed.

9. His family essentially asked the simple question of why Simon, a mentally ill person in the care of the State, died in this way, alone and untreated, under observation and in plain sight.

## THE AUTOPSY AND INVESTIGATION

10. Simon’s death was referred to the Coroner for inquiry and an autopsy was performed. Senior Forensic Pathologist, Dr Rianie Van Vuuren, conducted an autopsy on 22 September 2021. Dr Van Vuuren concluded that Simon died of a diffuse infiltrating spindle cell tumour and the consequences. In her report, Dr Van Vuuren recommended that an anatomical pathologist be consulted in respect of the cause of death.

11. On 12 July 2023, A/Professor Geoff Watson, a specialist in tissue pathology and diagnostic oncology, reviewed the matter and concluded that Simon had not died of a tumour but rather Chronic peptic ulcer disease (Helicobacter-related duodeno-pyloric ulcer), penetrating into the lesser sac, pancreas and into the liver. Dr Van Vuuren agreed with the opinion of A/Professor Geoff Watson.

12. The primary focus for the inquest is to determine why and how Simon’s ulcer was not identified and treated when he was in custody.

## STATUTORY ROLE OF THE CORONER

13. Jurisdiction is found under s 21(1) of the *Coroners Act 2009* to conduct this inquest because the death was a reportable death or there is reasonable cause

to suspect that the person's death is a reportable death. The term "reportable death" is defined in s 6(1) of the *Coroners Act 2009* and includes where the reason for the person's death is unknown or the circumstances of the death are unusual.

14. 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.

15. 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 Simon's care.

16. 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.

17. 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.

18. The statutory focus of this inquest is on determining the manner and cause of death, making formal findings of fact and deciding whether to make recommendations.

19. In these circumstances where Simon's death occurred whilst Simon was in lawful custody, an inquest was mandatory pursuant to ss 23 and 27 of the *Coroners Act*. The legislation provides that inquests are mandatory in connection with deaths which occur whilst a person is in the custody of the State. It is the nature of imprisonment that a person who has been lawfully deprived of liberty and autonomy is necessarily thereafter limited in relation to making decisions about

the type of medical and allied healthcare they access, when they access it, and whether they wish to present to hospital if they consider it necessary.

20. Persons in custody are necessarily reliant on the State, and the facility in which they are incarcerated, to provide an adequate level of care. A review of the circumstances of Simon's death is an important safeguard against the State becoming complacent in the provision of custodial and healthcare services to inmates, or otherwise allowing a system to develop which does not honour or respect the expectation that healthcare services available in the criminal justice system be commensurate with those that are available in the community.

21. The Act provides pursuant to s 81 that I must record formal findings, if findings can be made, with respect to Simon's identity; the date and place of Simon's death; and the manner and cause of death. The identity, date, and place of death is non-controversial:

    a. The deceased is Simon Mark Cartwright.

    b. Simon died on 19 September 2021.

    c. The location of his death was the Darcy 1 Pod within the Metropolitan Remand and Reception Centre in Silverwater, New South Wales.

22. The evidence also establishes the cause of death. It is uncontroversial that the cause of death was septic shock secondary to chronic peptic ulcer disease caused by infection of the gastric and duodenal mucosa with the Helicobacter pylori organism. Simon had an ulcer in his small intestine that penetrated into his abdominal cavity and surrounding organs. The penetration of surrounding organs allowed bacteria to enter into his blood stream, resulting in his death by septicaemia. This was not in dispute at the inquest. The opinion of anatomical pathologist, A/Professor Watson, was accepted by all experts, including Dr Van Vuuren, the forensic pathologist who conducted the autopsy.

23. The inquest focused on the manner of Simon's death, and in particular, sought to identify the time of his death with greater precision given that remained unknown. The time of his death was also related to the manner of his death. Simon was discovered already deceased by CSNSW staff.

24. The manner of Simon's death requires exploring carefully in the circumstances. He was one of the most vulnerable in our community. The legislation requires that those in custody are reviewed when they die in the system, because it is the State that is responsible for those incarcerated.

25. Simon was not a sentenced inmate, but was being held on remand. He had not been found guilty of the commission of any offence. He was, at the time of his death presumed to be innocent at law. It may have been that the charges would proceed to a defended hearing, or that he may have pleaded guilty, however the matter would have been dealt with summarily. This means that he may have been able to proceed pursuant to the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* and have his matter diverted into the mental health system. There may have been other sentencing options available to the Court, other than a custodial penalty.

26. Not only was Simon vulnerable as an ordinary detained prisoner, he was also assessed as being a 'mentally ill' person pursuant to the *Mental Health Act 2007*, which is an important distinction from suffering with a mental illness, making him even more vulnerable. Even given that he was already detained, being observed, had a RIT, and was contained within a cell, it was decided that he required treatment in a mental health facility. This fact was telling in relation to the extent of his mental illness. He was awaiting attention at the Long Bay Forensic Hospital. While he waited for that help, he was kept in the main prison facility. He had limited access to doctors and nurses, and was reliant on the CSNSW staff for his care.

27. The Issues List identifies the issues relevant to manner of death, and the appointment of the time of death:

    e. Whether Simon's clinical condition, both with respect to his physical and mental health, was, bearing in mind what was known and ought to have been known, properly investigated, diagnosed and managed during the period of his incarceration from 21 August 2021 to 19 September 2021.

    f. The date by which Simon ought to have been transferred to a mental health facility, such as the Long Bay Forensic Hospital, particularly bearing in mind the order made pursuant to s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* dated 3

September 2021, and the extent to which the failure to treat his mental health condition impeded diagnosis and treatment of his gastrointestinal issues; and

g. With respect to the provision of care by Corrective Services NSW ('CSNSW'):

   i. the appropriateness of Simon's housing in the Darcy 1 Pod during the entire period of his detention;

   ii. the appropriateness of shutting off Simon's access to water in his cell, and the management of his access to water; and

   iii. the adequacy of the observations of Simon, both by CCTV and correctional officers who were tasked with physically observing Simon in his cell, particularly on 19 September 2021.

## BACKGROUND TO SIMON AND HIS LIFE

### *Factual Background*

28. From the outset I wish to thank the team assisting in the inquest. Counsel set out both in opening and closing the factual matrix of the case, and I have heavily drawn from both the opening and closing, often directly, in relation to non-contentious areas, of which there were many in this case.

29. The outline of facts, as prepared by Mr Robinson and Ms Heath, is drawn from and repeated for the most part below.

30. Simon was born to Frances and John Michael Cartwright on 27 June 1980. He grew up in Tamworth, New South Wales. He was the youngest of five children, brothers Michael and John, and sisters Clare, Michelle, and Alison.

31. He and his family enjoyed a happy childhood. In the family statement he was described as a happy and engaging child. The family sat through the inquest, highlighting the importance that Simon had in their lives. He was dearly loved, however, at age 17 he was introduced to cannabis and, shortly thereafter, there were instances of domestic violence directed towards his parents which resulted in the making of Apprehended Domestic Violence Orders for the protection of his family.

32. Simon was described as a loved son and brother, spoilt by his parents and siblings. He was incredibly smart and musically talented, treasuring his beloved guitar throughout his life. Later, he became a fun and cherished uncle to his many nieces and nephews.

33. As his family noted, Simon was no angel, and began to “go off the rails” as described by them, in his mid to late teens. He battled cannabis addiction and mental health issues, with many ups and downs throughout his adult life. However, as recognised during this hearing, Simon actively sought and maintained treatment for long periods during these lows.

34. The family spoke of their heartbreak at not only his loss, but the manner of his passing. His mother was understandably particularly and distressingly impacted by the way in which he died. The family were struggling with unanswered questions in relation to his death. They were greatly saddened by the fact that he died most likely in pain, untreated and alone.

***Diagnostic and treatment history***

35. It was in 2008, aged 28, that he was diagnosed with Schizophrenia, and in 2013, at aged 33, he was diagnosed with bipolar disorder. The evidence supports that until about 2020 his psychiatric condition and health was well-managed. From a physical perspective, Simon had asthma and was diagnosed with gastro-oesophageal reflux in 2010. He also had neck and back pain, but otherwise physically reasonably well.

36. From 2013, he had a regular GP, Dr Iqbal. He regularly saw Dr Iqbal, and in the two years and nine months prior to his death, a Medicare History Statement shows 34 visits for prescription of psychotropic medication, for colds, for vaccinations, and other routine medical needs. Including Dr Iqbal, there were 73 occasions of self-initiated interaction with healthcare practitioners, including his psychologist, John McDonald in that time.

37. A review of Mr McDonald’s notes reveals that Simon was engaged with treatment, had insight into his mental illness, was polite, and was honest about his drug misuse. Throughout this primary care documentation, he was reported to be engaged in cognitive behavioural therapy until the final months when it appears his drug use increased, and his mental health deteriorated.

38. Documents produced by the Pharmaceutical Benefits Scheme demonstrate that Simon reliably filled his prescriptions for psychotropic medication, allowing the inference to be drawn that he was taking his mental health medication.

39. In mid-2020, Simon began to seek opioid analgesia and benzodiazepines from Dr Iqbal, causing the relationship between Simon and Dr Iqbal to break down. Dr Iqbal determined not to continue to see Simon for "personal safety reasons". Prior to that decision, Dr Iqbal's clinical records reveal a number of occasions from 2020 on which Simon was aggressive and threatening, and his presentation was consistent, so the notes reveal, with being affected by illicit substances.

40. Simon had a number of interactions with other doctors and the hospital system in 2020. He had an admission to the Illawarra Community Mental Health Service between 10 February 2020 and 15 February 2020, and again between 14 May 2020 and 18 May 2020.

41. On 6 July 2020, there was a significant change in the management of Simon's psychiatric condition, and until that stage his diagnoses of schizoaffective disorder and bipolar disorder remained. On that date, he was brought to Shellharbour Hospital by the community mental health team. He presented with agitation in the context of having expressed thoughts of harm to others.

42. Simon was reviewed by a psychiatrist, Dr Tietze. Dr Tietze recorded agitation and "tantrum-like" aggressive behaviour when challenged in respect of his conduct. Dr Tietze did not elicit symptoms consistent with psychosis but instead determined that on that presentation Simon was experiencing a substance induced behavioural disturbance complicated by narcissistic personality features. Although Simon had a decade-long diagnoses of schizophrenia and bipolar disorder were reformulated to a severe cluster B personality disorder with prominent narcissistic and histrionic features and polysubstance use disorder (methamphetamine, cannabis and alcohol). This change resulted in the discontinuance of the antipsychotic medications he had been taking for the previous decade.

43. The decision to change the diagnosis, particularly of bipolar disorder, caused Mr McDonald, who was Simon's psychologist, significant concern. His records corresponding to a telephone call on 19 September 2020 with Simon relevantly records, "said he was not on medication anymore… rediagnosed by mental

health team psychiatrist", which is presumably a reference to Dr Tietze, "personality disorder". Mr McDonald's notes record, "I warned him against this". Mr McDonald recommended Simon seek a second opinion. His records disclose that he was concerned Simon would become a problem for police, and that "potentially could go to gaol", if his psychiatric condition was not properly managed.

44. Mr McDonald and Simon had a good developed therapeutic relationship. Mr McDonald knew him well and had a good understanding of Simon's psychological condition.

45. Simon had a further admission to Shellharbour Hospital from 28 August 2020 to 10 September. That admission was initiated by a referral from the community mental health team for psychosis. During this admission his weight was noted to had dropped from 99kg on 8 August 2019 to 85kg.

46. During his admission he was observed to display aggressive "intrusive and highly disruptive" behaviours. There was no treatment or investigation in respect of the cause of his weight loss.

47. Simon first attended Wollongong Hospital for an upper gastric bleed on 13 November 2020. He was complaining of 1 day of vomiting and blood in his stool. During his admission, he became aggressive and a code black behavioural emergency was called by staff. Simon discharged himself against medical advice before returning on 14 November 2020. By that time, he had developed rectal bleeding. He underwent gastroscopy on 16 November, together with biopsy of abnormal tissue. He was found to have a duodenal ulcer, which is an ulcer in the small intestine. His weight was recorded variously as 65kg and 72kg on this admission, which represented weight loss since his 10 September admission of at least another 9kg and up to 16kg, depending on the record.

48. Simon was discharged on 17 November 2020. At discharge he was prescribed pantoprazole 40mg twice daily. Pantoprazole is a proton pump inhibitor ('PPI'). As Dr Vickers, gastroenterologist, explains in his report, PPIs operate to suppress the development of acid in the gut which aids healing of the ulcer. As is apparent from Dr Vickers' report, duodenal ulcers are readily amenable to treatment and in the majority of cases, can be cured.

49. On 23 November 2020 Simon was re-admitted to Wollongong Hospital with further rectal bleeding. The source of the bleed was unknown, but it was considered likely from either the ulcer or the scar left by the biopsy taken on 16 November. Pathology results revealed Simon's haemoglobin had dropped to 47, indicative of severe anaemia, such was the extent of his blood loss, and he required a blood transfusion. He underwent repeat gastroscopy which demonstrated an ongoing non-bleeding duodenal ulcer. After the procedure he became agitated and aggressive and discharged himself against medical advice. During this admission, it was confirmed that a Helicobacter Pylori infection was causing the ulcer and Simon was prescribed appropriate oral dual antibiotic therapy and the continuation of Pantoprazole.

50. On 24 November 2020 Simon was readmitted to Shellharbour Hospital after being detained by police pursuant to s 22 of the *Mental Health Act*. During this admission a urine drug screen was positive for cannabis and benzodiazepines but negative for methamphetamine, which was consistent with the history Simon provided on admission. There was no evidence of ongoing gastrointestinal bleeding.

51. On 10 December 2020 Simon attended Shellharbour Hospital with significant thought disorder and complaining of abdominal pain. He expressed frustration at how unwell he was and stated, "I can't eat, the bugs are eating my stomach". He reported that he was "sick in the head" and that he had ongoing "chatter" in his head. Urine drug screen was negative for amphetamines and positive for cannabis. A diagnosis of psychosis in the setting of polysubstance use (methamphetamine and cannabis) was made. Simon was requesting medications for his thought disorder, but these were not prescribed. There was no investigation in respect of his complaints of abdominal pain.

52. He presented again on 31 December 2020 with abdominal pain, again recently using both cannabis and methamphetamine as per his patient history. Again, he requested antipsychotic medications to help with his mental health disorder, but this appears to have been refused.

53. It was at about this time that Dr Iqbal's longstanding relationship with Simon came to an end. Dr Iqbal's notes reveal that a consultation occurred on 7 January 2021. Simon reported that he had lost 30 kilograms. He does not appear to have been

weighed, but that weight loss figure is consistent with other weights which are known. He was asking for risperidone and Valium. He was noted to be manic, with pressured speech. Drug use was suspected by Dr Iqbal. Simon was advised to present to hospital for mental health assessment and informed that if he did not attend the hospital, Dr Iqbal could not continue to treat him as he was not compliant with Dr Iqbal's advice. A later entry in the records, which was made on 18 March 2021, relevantly records, "Continuation of notes from 7 January. Last time seen on above mentioned dates. Under influence of drugs. Drug abuse. Threatening and aggressive. Mania. Told patient I can not look after him any more for personal safety reasons". Simon did not see Dr Iqbal again after 7 January 2021.

***Criminal history – First relevant incarceration – January 2021***

54. On 9 January 2021, Simon was charged with the criminal offences of Stalk/Intimidate and affray. The circumstances alleged were that he lit a fire in a neighbour's apartment.

55. On 10 January 2021, Simon was bail refused. He was admitted to MRRC. He threatened self-harm and was placed on a Risk Intervention Team ('RIT') Management Plan. He was accommodated in Darcy 1 Pod at MRRC under observation.

56. The RIT is an inter-service multidisciplinary team comprised of two CSNSW correctional officers and a Justice Health mental health nurse, the role being to focus upon triage, assessment, and management of inmates who are identified as being at a risk of harm to themselves, others or by others within a correctional centre.

57. Simon underwent a Reception Screening Assessment ('RSA') on 10 January. RSA aims to identify people that may have a health problem upon their entry to custody, so that referrals, ongoing assessment and management can be arranged. The 10 January 2021 RSA records that Simon weighed 69 kilograms, with a Body Mass Index of 23, which is in the normal range.

58. A history of gastric ulcer was noted. The RSA reflects that Simon denied all substance use except cannabis. Health conditions recorded on the RSA in January included personality disorder, gastric ulcer, melaena and schizophrenia.

Following the RSA, Simon was prescribed a PPI in the form of Pantoprazole 40 mg twice daily. Simon reported six weeks prior to his admission having undergone a blood transfusion in Wollongong Hospital. Appropriately, requests for information were sent to Shellharbour Hospital and Wollongong Hospital, and records were produced by both. The records confirmed Simon's account of suffering from a gastric ulcer, having experience melaena, and having undergone a transfusion.

59. From 10 January onwards Simon was reviewed by the RIT daily and was generally observed to be agitated, thought disordered, easily irritated and elevated. His RIT management plan continued throughout the course of his time in custody.

60. On 16 January 2021, Simon flooded his cell by letting a tap run continuously and was observed to be "cleaning the toilet and the cameras". On 19 January 2021, Justice Health clinical nurse consultant Amanda Jahan prepared a report to the Local Court of NSW in relation to Simon's mental health presentation. He was assessed as being "thought disordered, grandiose, pressured and highly agitated". Ms Jahan found he was suffering a relapse of schizoaffective disorder likely due to medication non-compliance and substance abuse in the community and was of the view that he was a "mentally ill person" within the meaning of the legislation. In her report to the Court, she recommended Simon be dealt with under s 33 of the *Mental Health (Forensic Provisions) Act*.

61. Simon flooded his cell again on 20 January 2021 and was observed to be "dishevelled, screaming…asking for water, agitated, not answering any questions, distressed and banging on cell door, not taking medication…".

62. On 22 January 2021 Simon's matter was before the Wollongong Local Court. The Magistrate had available to them the report of Clinical Nurse Consultant Amanda Jahan which recommended that Simon be dealt with under s 33 and transferred to a mental health facility. The Magistrate made that order and Simon was accordingly transferred from MRRC to Cumberland Hospital.

63. Throughout Simon's time at Cumberland Hospital, he received Clonazepam, which is a benzodiazepine, sodium valproate for bipolar disorder, and zuclopenthixol for schizophrenia. Although clinicians at Cumberland Hospital regarded his diagnosis as controversial, they, unlike Dr Tietze earlier, took the

view that medication for bipolar disorder and schizophrenia was indicated. Simon was also maintained, while he was at Cumberland Hospital, on Pantoprazole.

64. Simon did well at Cumberland Hospital. On discharge on 22 February 2021, the following was written about him:

> "On assessment at the day of discharge, Simon was well-kempt, polite and co-operative. Engaged well and maintained a good eye contact. Reactive in affect, congruent with mood. Speech was well articulated, coherent with normal rate, rhythm and tone. Did not exhibit any psychotic or pervasive mood symptoms. Had no thoughts of self-harm or suicide. Denied thoughts of harming others. Able to hold a linear and logical conversation, had capacity to consent and capable of making informed decisions. Moreover, willing to engage with Acute MH team. Therefore, the treating team had no grounds to detain under the Act. Found not a risk to self or risk to others at this point in time."

65. Accordingly, on 22 February 2021 Simon was discharged from Cumberland Hospital to MRRC, and on 23 February he was released from MRRC.

***Mental Health history between first and second incarceration***

66. On 8 July 2021, Simon was conveyed to the Mental Health Unit at Wollongong Hospital by police. He was so conveyed after he made approximately 35 phone calls to emergency services during which he was making what were said to be nonsensical complaints. He was kept in hospital for observation overnight, and was reviewed by Dr Tietze.

67. Dr Tietze, and others, adhered to their diagnosis of severe personality disorder. He was not considered to be psychotic and was not considered to meet the criteria for ongoing involuntary admission. He was requesting discharge, and so was discharged. During this admission, an emergency department management plan was created for Simon which provided that he was not to be admitted under the mental health team for agitated mood, aggression, and intimidating behaviour in the absence of clear evidence of psychosis. Agitated mood, aggression, and intimidating behaviour was recorded in the management plan as having been longitudinally observed in an inpatient setting and found not to be consistent with a major affective illness or psychosis.

68. On 2 August 2021, Simon was again conveyed to Shellharbour Hospital by police after an incident in which was found running through traffic, yelling, and head-butting himself against a bus stop. In accordance with the emergency department management plan, his agitation, aggression, and intimidating behaviour was determined not to be a product of psychosis. Accordingly, he was not found to be a mentally ill or mentally disordered person. He was administered clonazepam to assist him to calm down and he was discharged home.

69. Again, on 13 August Simon was conveyed to Shellharbour Hospital by police. He was assessed in the early hours of 14 August and was managed in accordance with the previously formulated emergency department management plan. He was found not to be psychotic and was discharged home.

***Second relevant incarceration - 19 August 2021***

70. On 19 August 2021, Simon was charged with stalk/intimidate and trespass offences. On 20 August 2021, Simon was charged with further offences, including assault and resisting police. He did not apply for bail.

71. On admission into police custody, Simon was assessed by Justice Health and found to be exhibiting "significant behavioural issues". The mental health nurse who assessed him recorded that Simon was "extremely verbally aggressive" and formed the view that he was intoxicated during the assessment. He was referred to Drug and Alcohol and for a psychiatric mental health review.

72. On 21 August 2021, Simon was transferred from the police cells to MRRC. A RIT Management Plan was subsequently activated due to self-harm and aggressive behaviour. He was held in Darcy 1 Pod in Cell 35, for the purpose of assessment and classification. At this time, the Darcy 1 Pod was also being used as a main reception and quarantine area for inmates who were COVID positive or awaiting testing for COVID.

73. Simon was required to undergo daily COVID-19 checks, including daily temperature and welfare checks, until 4 September 2021. He was reportedly frequently aggressive towards Justice Health staff and refused to submit to temperature checks. The instructions were that Simon was to remain in Cell 35 of Darcy 1 Pod until he was cleared by the RIT and had completed 14 days of quarantine on 4 September 2021.

74. On 22 August 2021, he was reviewed by the RIT and was observed to be “very angry, demanding medication, not communicating, yelling and screaming”. The RIT ordered Simon to remain on the RIT Management Plan and ordered an urgent review by a psychiatrist.

75. On 23 August 2021, Justice Health nurse Anil Bishwokarma was conducting quarantine and isolation checks on all inmates in Darcy 1 Pod. On this day, Simon refused to answer the questions on the isolation checklist or to have his temperature taken. A Justice Health nurse also attempted to screen Simon in accordance with the RSA protocols, however Simon refused to approach the cell door or answer any questions.

76. On 24 August 2021, he was assessed by the RIT and a Justice Health mental health nurse. Progress notes indicate that Simon was engaging in antisocial behaviour including yelling at staff; refusing to be screened; and refusing to answer the COVID-19 checklist questions or have his temperature taken. It was noted that he presented as “agitated, aggressive, loud and highly irritable” and a recommendation was made for him to be reviewed by a psychiatrist.

77. On 25 and 26 August 2021, Simon was reviewed by the RIT. He presented with “elevated mood, pressured speech, disinhibited behaviour (naked) and his door cell was covered in food.” A psychiatric review was again recommended on both occasions.

78. On 27 August 2021, Dr Matthew Hearps, psychiatrist, reviewed Simon in his cell. Dr Hearps made a diagnosis of schizoaffective disorder, bipolar type presenting with elevated mood, disorganised behaviour, and persecutory delusions in the context of medication discontinuation. Dr Hearps prescribed Risperidone and Sodium Valproate. He also recommended that Simon be transferred to the Mental Health Screening Unit. He directed that there be a review by a Justice Health mental health nurse in a week’s time, and by a psychiatrist in two weeks’ time. He was to remain on the RIT Management Plan.

79. Also on 27 August 2021, Justice Health mental health nurse Nisish Sharma prepared a Health Problem Notification Form (“HPNF”) which noted that Simon had been assessed by a psychiatrist and was awaiting a bed in the Mental Health Screening Unit (“MHSU”).

80. On 28 August 2021, the RSA was completed. The RSA was required by policy to be completed within 24 hours of a patient entering a correctional centre. The Registered Nurse who completed it, Deanne Wood, recorded that the reason for the delay in the completion of it was “Patient mentally unwell and unable to participate”.

81. Also on 28 August 2021, Simon was reviewed by the RIT through his cell door. Initially he refused to engage, however, he later told the RIT that he was “in pain” and requested medication. Following further questioning, he reportedly “changed his story and said he was ok”.

82. On 29, 30 and 31 August 2021 and 1, 2 and 3 September 2021, Simon was reviewed by the RIT. The team assessed him as “difficult to engage with” and noted intermittent periods of medication compliance; ongoing thought disorder; and persecutory delusions. On one occasion, his cell was flooded with water after he turned a tap on and let it continue to run. Continuation of the daily RIT review and referral for a MHSU placement within MRRC was recommended, although that placement had already been recommended by Dr Hearps on 27 August.

***Simon is determined to be a mentally ill person on 3 September 2021***

83. On 3 September 2021, Simon was again reviewed by Dr Hearps. He found Simon to be naked in cell. Simon was yelling, his speech was fast, and he was agitated. Dr Hearps found his thought form to be tangential with persecutory themes, although did not consider that he was hallucinating. Simon complained that his psychotropic medication was inadequate and requested an increased dose, but Dr Hearps observed also that the notes disclosed that Simon had not been taking his medication, including risperidone and sodium valproate.

84. Dr Hearps formed the view that Simon’s mood remained elevated and that he was exhibiting behavioural dyscontrol. He determined that Simon was a mentally ill person in accordance with the prevailing legislation, that care of an appropriate kind was not available in a correctional facility, and that Simon required transfer to Long Bay Forensic Hospital. Pending that transfer, he determined that Simon should continue to be offered his medication under supervision and should, if a cell becomes available, be transferred to the MHSU.

85. Having formed that view, Dr Hearps accordingly completed a certificate pursuant to Schedule 1 and s 86(4) of the *Mental Health and Cognitive Impairment Forensic Provisions Act* for the involuntary transfer of Simon to a mental health facility. In a letter of 3 September 2021 authored by Dr Hearps, he recorded, "Mr Cartwright is a mentally ill person as that term is defined in the Mental Health Act. His illness is characterized by a severe disturbance of mood, disorganised speech and behaviour and persecutory delusions. He has experienced an exacerbation of his condition in the context of medication noncompliance. Care of an appropriate kind is not available in a correctional centre as he is refusing treatment in this setting."

86. In order for an order to be made for transfer of a correctional patient to a mental health facility, a second medical officer, in addition to Dr Hearps, was required to complete a certificate pursuant to Schedule 1 and s 86(4) of the relevant Act. Simon was then seen by Dr Vivek Srinevasan, then a psychiatry registry but not a specialist psychiatrist. Dr Srinevasan found Simon to be elevated, extremely irritable, pressured in speech and shouting. He observed that Simon was naked and provided a thought-disordered explanation as to why he was naked. Dr Srinevasan observed significant psychomotor agitation. He recorded that Simon was non-compliant with treatment and posed a significant risk to safety. His transfer to a mental health facility was recommended and Dr Srinevasan completed a certificate recommending that transfer.

87. The final step for transfer, being the signing of an order for transfer, occurred on 3 September 2021. The order was signed by Dr Sarah-Jane Spencer, Co-Director Services and Programs (Clinical) for Justice Health and Forensic Mental Health Network.

88. While Dr Hearps, Dr Srinevasan, and Dr Spencer moved quickly to facilitate the making of the order for transfer, limitations in the system, and relevantly the availability of beds were such that Simon was never transferred to Long Bay Forensic Hospital. He remained in the Darcy 1 Pod from the time the order was made on 3 September 2021, until his death on 19 September 2021.

89. Once the s 86 order for transfer was made, Simon was placed on the Long Bay Hospital Mental Health Unit ('LBHMHU') wait list on the Patient Administration System (PAS). Admissions to the LBHMHU are discussed at the weekly

LBHMHU Bed Demand meeting. The order of patient admissions is generally based on clinical need.

90. No vacancies existed in Long Bay Forensic Hospital at this time. Simon was on the waitlist for the duration of the period. On 7 September 2021, Simon was number 9 on the List for transfer. Examination of the waitlist issued on 14 September reveals that he was number 2 on the list for transfer.

91. After the order was made on 3 September 2021, Simon continued on daily RIT from 4 to 17 September 2021. During this period, he presented as elevated in mood, refused to engage with staff and appeared generally agitated with disorganised behaviour such as yelling, banging on his cell door, and swearing loudly. He was assessed as remaining a risk to others. At times, staff observed food and vomit on the cell floor, and also with Simon to be talking to himself about things reported such as “biblical things…that did not make sense”.

***Simon remains in custody from 3 September 2021***

92. On 15 September 2021, Simon was transferred to Cell 37 of Darcy 1 Pod at the MRRC. He remained there until his death. Cell 37 is a safe cell, and is designated to be under constant video surveillance and is one of the camera cells located within the Darcy 1 Pod area ordinarily used to house inmates at greater risk of self-harm or injury due to intoxication or mental health conditions (referred to as ‘RIT inmates’). The cell allows for greater observation of the inmates, with two CCTV cameras within the cell and a clear Perspex door and front of the cell to allow observation of the inmates within the cell externally.

93. The reason for the change of cell placement was related to a maintenance issue. On 15 September 2021, Simon reported to the RIT that he had been “feeling sick all night”. The RIT observed water on the floor mixed with urine and possible faeces or food scraps stuck to the cell walls. The RIT terminated the review because Simon complained he was having difficulty hearing the RIT officers.

94. On 16 September 2021, it emerged just prior to the hearing that a Telephone Order Medication Chart, which was not previously available, discloses that on that date a telephone order for Pantoprazole was made.

95. On 17 September 2021, Simon was again reviewed by Dr Hearps. That review was triggered in part, by the requirements of s 89(4) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* which provides that if a person is not transferred to a mental health facility within the period prescribed by the regulations, relevantly, 14 days – a limited review must be conducted by the Mental Health Review Tribunal. Following Dr Hearps' review of Simon on 17 September, he prepared a letter to the Tribunal which indicated that Simon continued to require a higher level of care and monitoring than was available at MRRC, and that he continued to demonstrate behavioural dyscontrol and agitation. It was noted that he had not been admitted to a mental health facility because "other patients with higher priority have been admitted before him".

96. Over the course of 17 and 18 September 2021, Simon covered and uncovered the cameras in his cell on numerous occasions. From approximately 9pm onwards on 18 September 2021, both cameras in his Cell 37 were covered.

97. On 17 September 2021, Simon made numerous 'knock up' calls requesting a sandwich, requesting a blanket, and requesting numerous times that the water to his cell be turned on. It emerges, although it is not well documented, that it was turned off because Simon had flooded his cell. This is a summary of some of those calls:

    a. At 5:04 pm on 18 September, Simon has the following exchange with a CSNSW officer:

        CSNSW: Yeah?

        Simon: Yeah it's not about me its not about my troubles. CSNSW: I can't hear you its breaking up. I'll come and see you. Simon: You have to understand I'm struggling to breathe.

    b. At 5:09 pm on 18 September, Simon has the following exchange

        CSNSW: Medical?

        Simon: Yeah um sorry just give me a sec, I'm standing in front- just give me a few minutes to breathe.

        CSNSW: You're not doing yourself a favour just go to sleep.

c. At 5:46 pm, he makes a frantic request for water which request is apparently regarded as humorous by the correctional officer who fielded the request:

CSNSW: Yeah this is really entertaining actually.

Simon: CAN YOU TURN THE WATER ON.

CSNSW: Yeah keep buzzing up actually this is keeping me entertained.

d. At 5:49 pm, after having just knocked up and requested the water be turned on, he was told that if he keeps quiet for 30 minutes, the water will be turned on.

e. At 7:48 pm, there is the following exchange in respect of the water being turned back on.

CSNSW: Medical?

Simon: Can you turn the water on please.

CSNSW: If you don't behave like that we will.

98. There is no evidence as to what precautions were taken during the period in which water to Simon's cell was turned off to ensure he had access to sufficient drinking water. The CCTV does not disclose that he was brought additional drinking water during this time.

***Events of 19 September 2021***

99. On the morning of 19 September 2021 at 7:27am, RN Anil Bishwokarma attended Darcy 1 Pod to assess inmates in COVID-19 quarantine. Simon continued to be subject to such checks since 21 August; a period of nearly one month. Simon was observed by RN Bishwokarma lying on the floor of Cell 37 on a mattress under a blanket. Nurse Bishwokarma and a CSNSW officer knocked on the door. RN Bishwokarma asserts that he observed Simon's foot to move. He says he assessed that Simon was likely asleep and determined to move on to check on other inmates.

100. At approximately 7:54am, Correctional Officer Tamer Rabadi attended Cell 37 to undertake a headcount with Correctional Officer Leon De Marinis. Simon did not

respond to their attempt to engage him, which including knocking on the Perspex cell door and calling out to him. CO Rabadi observes that this was not unusual behaviour and that Simon would often sleep for long periods.

101. COs Rabadi and De Marinis sought advice from CO Kevin Blythe. The three officers attended Cell 37 together shortly after 8:05am, where CO Blythe approached him lying on the cell floor. CO Blythe called out and attempted to rouse Simon, to which he apparently responded with words to the effect of "fuck off". The cameras within Simon's cell, were obscured at this time and there is no CCTV footage of this interaction. However, a camera located in the Darcy 1 Pod common area consistently shows the three correctional officers entering Cell 37 as described.

102. At around 11:30 am on 19 September, COs Rabadi and Kamboj were distributing lunches to the inmates in Darcy 1 Pod. At 11:36am, CO Rabadi looked into Cell 37 and observed Simon to be lying consistent with sleep. CO Rabadi opened the cell door and placed lunch on the corner of his bed. In his statement he observes that, due to the concerns around COVID exposure held at the time, "all inmates in Darcy 1 Pod were to be treated as if they were COVID positive so I wanted to limit my exposure inside the cell; for my own safety and the safety of my colleagues and other inmates".

103. Lunch on 19 September 2019 was a sausage roll. While food, and food scraps were located in Simon's cell after his death, that sausage roll was not located in Simon's cell. It raised the possibility that he ate it. Examination of a photograph of the contents of Simon's stomach by Dr Van Vuuren does not indicate, one way or another, whether the sausage roll was consumed. However, the OIC was, during the hearing, able to locate the sausage roll. It appeared it had moved to outside Simon's cell and that another inmate in the next cell asked for it and was given it from the floor by a CSNSW officer.

104. At around 12:00pm, RN Nikita Vora attended the cell to administer Simon's medications to him. The hatch to Cell 37 was opened, and Simon was seen lying on the ground partially covered by a blanket, naked. The CSNSW officer accompanying Ms Vora called out "Cartwright, your meds", however he did not respond. Ms Vora also called out Simon's name. She formed the view he was

sleeping. Ms Vora entered an 'R' into the Justice Health patient progress note, an indication that he had refused his medication.

105. A file note was prepared by Ms Vora at 12:59pm, which noted that Simon had been observed "through the door" of his cell and was not taking his medications. Ms Vora further noted that he was "called for meds by the Author and officer, but no response. Patient lying on the floor."

106. At approximately 1:24pm, CO Rabadi briefly entered Cell 37 to deliver the evening meal, lasagna. CO Rabadi says that on looking into Simon's cell, he observed Simon to be sleeping. He says he made a "split-second decision" to open the cell door and "quickly place his dinner on the corner of the bed". He recalls he said, "Cartwright, dinner" before quickly exiting. In his statement, CO Rabadi noted that he did not hear a response at this time, and that he "only took the risk of entering the cell because [Mr] Cartwright appeared to be sleeping and settled." And the lasagna placed on the end of his bed remained and is depicted in photographs from the crime scene.

107. At around 2:00pm, CO Giovanni Panuccio commenced his shift as the Observation Officer at Darcy 1 Pod. He says in his statement that he saw Simon "settled…and lying on his mattress on the floor. I remember he was naked but that in itself is not unusual. I also noticed his testicles were visible and he moved his left leg as I watched him."

108. CCTV footage reveals CO Giovanni Panuccio looked into Simon's cell at 2:17pm.

109. CO Panuccio said he conducted another round of physical checks around 3:00pm to 3:30pm and "…when I next physically looked in on [Mr] Cartwright, I noticed his testicles were no longer visible leading me to believe he had moved and there was no cause for concern. Given [Mr] Cartwright's history of non-compliance I saw this as a positive; in that he was sleeping and settled."

110. The CCTV footage from 3:00pm to 3:30pm shows that CO Panuccio delivered food to Cell 38 around 3:01pm. Another CSNSW officer attended Cell 38 and spoke with the inmate for a short time at around 3:06pm to 3:07pm but also does not appear to look at Simon in the neighbouring cell. Around 3:14pm and 3.19pm, CO Panuccio again spoke with the same inmate in Cell 38, but did not appear to look into Simon's cell.

111. At approximately 4:00pm, CO Panuccio reported that he noticed that the cameras in Simon's cell were "covered", such that he "could not see what was happening in the cell." CO Panuccio stated that he attempted to 'knock up', and that evidence is supported by the audio of the knock up. He knocked up at 3:41 pm, stating only "Cartwright". There was no response.

112. Around 5:30pm, CO Mohan, from the Main Control Room, contacted CO Panuccio and requested that he ask Simon to remove the object blocking view of the cameras in Cell 37. CO Panuccio again attempted to 'knock up". He said, "Hey mate, 37. Cartwright. Cartwright, wake up." There was no response. The CCTV footage does not reveal CO Panuccio taking any further steps, such as visiting Simon's cell, nor was there any further contact via the knock up system.

113. At around 6:30pm or 7:00pm, CO Panuccio reported that he observed Simon during a physical check and noted that he "still appeared to be asleep". CCTV footage from this time does show CO Panuccio walk past Cell 37 around 6:37pm. He is seen to glance in the direction of Simon's cell.

114. At approximately 7:30pm, RN Lorenzo Tolentino began administering medications to the inmates on Darcy 1 Pod, accompanied by CO Milton George. RN Tolentino attended the cell and called Simon's name. He advised that they had Simon's medication. No response was received.

115. RN Tolentino peered into the cell using the viewing window and observed Simon to be lying in a "right lateral position" on the floor, naked. CO George then tapped on the Perspex cell. When Simon did not respond, CO George approached CO Panuccio in the break room and stated "Cartwright won't come to the door for his pills". CO Panuccio then attempted to engage Simon from outside Cell 37 with no response. CO Panuccio noted that "[g]iven [Mr] Cartwright's potential for aggression and the COVID environment in the pod, CO George and I were reluctant to enter the cell without advising the Night Senior."

116. CO Panuccio accordingly approached Senior Correctional Officer Matthew Dorrans ("SCO Dorrans"), informed him that Simon was not taking his medications. CO Panuccio reportedly also told SCO Dorrans that he had observed him to look "pale" and "not well" and that he was still lying on the mattress on the cell floor. CO Panuccio mentioned that the camera in Cell 37 was covered, about which SCO Dorrans was concerned about.

117. A decision was made to enter Simon's cell. CO Panuccio and SCO Dorrans put on PPE. SCO Dorrans called through the cell door and both SCO Dorrans and CO Panuccio banged on the Perspex with no response. CO Panuccio then opened the cell door and SCO Dorrans entered. CO George and RN Tolentino remained outside the cell.

118. Upon entering the cell, SCO Dorrans cleared the camera using a broom and pulled the mattress from under Simon, but Simon did not respond when the mattress was moved. Both SCO Dorrans and CO Panuccio observed there to be a significant quantity of rubbish in the cell, with food and food scraps scattered around the floor. There was a foul smell. SCO Dorrans removed the mattress from the cell and checked for possible weapons, before requesting that Mr Tolentino assess Simon.

119. Mr Tolentino entered Cell 37. He found Simon to be non-responsive. His skin was cold to the touch. He stated, "he's gone", indicating that Simon was dead. A medical response was appropriately called by SCO Dorrans, and he told CO Panuccio to commence a time log.

120. The medical response team arrived approximately 3-5 minutes after being called, Justice Health nurses Lai Yung and Marvin Santos attended. A decision was made not to commence CPR. At 7.38pm Simon was declared deceased. RN Yung prepared an incident report which noted that Simon had been found "lying on [the] floor…totally naked", not breathing, "pale and cold to touch...with rigid and very stiff muscles and joints." It was further noted that he had likely been deceased for a "prolong[ed] period".

***Evidence of staff within the facility***

121. SCO Dean was the A watch supervisor and gave evidence in statement and oral form. He assisted the inquest with information as to the nature of the shift, RIT and supervision. He provided information that there are communication tools available about an inmate including a muster book and a communication logbook. He didn't recall that those documents made observations of Simon or about his health status. SCO Dean recalled that Simon was on a RIT and so he would be "under constant watch, constant surveillance of some sort".

122. He was asked whether he knew that Simon had mental health concerns and he said that he did not. All he knew was that he was COVID positive and that he was under "good observation". However, he was aware that he was awaiting a bed at the MHSU.

123. This evidence was very helpful and is an example of the honest account of the limited understanding of why an inmate was there, and even the purpose of waiting to be admitted into the MHSU, highlighting the need for knowledge, education and training to those dealing with mentally unwell inmates.

124. SCO Dean also gave evidence that there was no dedicated officer allocated to sit in front of the TV monitor in relation to the 24 hour surveillance cells, and so during the period of A Watch, (7am-3pm shift) there is no dedicated observation officer. However, later he indicated that there would be an officer in the room to make sure the monitoring was occurring and he would say to the staff when he arrived "someone make sure someone is there watching the cameras" to make sure the cameras were watched at all times.

125. He also indicated that, in relation to the covering of the cameras, which he agreed occurred in this case for around eight hours, he would have been under the impression that someone would have attended to it within the POD staff.

126. SCO Dean had many roles to play as supervisor. As indicated to him during the inquest, he was able to provide very useful evidence of the practicality of what was known by Correctives staff generally, what the process was for observation and clearing of the cameras.

127. SCO Dorrans also gave evidence on these topics as a supervisor. At a certain part of the day, he would have been the most senior officer present in the facility. He noted that at that time he was not aware of any formal process in relation to the turning off of the water.

128. He was able to give evidence that when he was called to Simon's cell and pulled the mattress out from him, he was clearing the area, considering safety in the event that an inmate was playing "possum" and could not recall if Simon was totally on the mattress when he did this. He indicated in the evidence that he was very distressed at the death of Simon, and he had not experienced the death of an inmate before this occurred.

129. The language Mr Dean used was also an insight into the approach CSNSW officers might take in relation to an inmate. He said that he had been told that Simon had previously been abusing and aggressive towards staff, stating: "I made sure I cleared the CCTV camera because if he did get up and started throwing a punch I would have been covered. It would have been shown on camera".

130. This evidence highlights the difference in approach by a CSNSW officer and a medical professional. It highlights the understandable concern about aggression, as opposed to a focus on mental unwellness, and mental illness. Instead of a description of Simon being mentally very unwell, he was given the information that Simon had been aggressive, highlighting the distinction between the roles of CSNSW and JHFMHN.

131. RN Vora and RN Bishwokarma also gave evidence about the role of providing medication and checks on Simon. The tenor of this evidence was that particularly during COVID the involvement of these nurses was minimal. The checks were cursory, although there was a recollection of RN Bishwokarma that Simon moved his foot during the observation, however, did not make any response to her.

132. There is no criticism of any of these staff. However, the evidence disclosed minimal interaction with Simon. The fact that the inquest was considering evidence of proof of life as to the very minute detail of whether Simon's foot was seen to move, or if he was seen in a different state of covering while lying down demonstrates the very limited interaction that was had with Simon over an extended period of time.

133. I thank these witnesses for performing the difficult task of coming before the Court and providing information as to the practicality of what was occurring and expected in the busy shifts leading up to Simon's death.

***Treatment of Simon's physical health***

134. The inquest had the benefit of the invaluable assistance of experts, both independent.

135. Dr Vickers is a Fellow of the Royal College of Physicians, with a subspecialty in gastroenterology. He has been a physician since 1985 with a MBBS from the

University of Sydney in 1978, and is presently a consultant physician at St Vincents Private Hospital and St Vincents Clinic in Sydney.

136. Dr Quilty is a general physician, obtaining fellowship of the Royal Australian College of Physicians in 2013. He obtained his Bachelor of Medicine and Bachelor of Surgery from the University of Sydney in 2004 and was working as the senior staff specialist the Northern Territory at Katherine Hospital and Alice Springs Hospital, He is presently the medical advisor for purple house in central Australia and is a vesting medical officer for New South Wales health at Bellinger River District Hospital.

137. They both examined the brief of evidence that was provided to them, watched CCTV footage, provided an expert report and gave evidence for the benefit of the inquest.

138. As stated, there is no controversy as to the medical cause of Simon's death, being septic shock secondary to chronic peptic ulcer disease cause by infection of the gastric and duodenal mucosa with the Helicobacter pylori organism.

139. Dr Quilty considered Simon's weight loss was likely multi-factorial, relating to a developing gastroduodenal ulcer of which there is no mention of symptoms but would conceivably have reduced Simon's appetite, with homelessness and methamphetamine addiction also contributing. Dr Quilty observes that pathology results during this time suggest normal nutritional status.

140. The evidence of Dr Vickers was that Helicobacter Pylori infection is readily treated, and cured, with dual antibiotic therapy. Dr Vickers and Dr Quilty regard it as unlikely that Simon was compliant with his medication, particularly given the progression of the ulcer.

141. In the opinion of both Drs Quilty and Vickers, the gastric ulcer identified at autopsy was the same ulcer that was detected and diagnosed when Simon was admitted to Wollongong Hospital in November 2020, however the dual antibiotic therapy that had been prescribed to Simon in Wollongong Hospital had failed to eliminate the underlying Heliobacter pylori infection, which would have been likely due to his self-discharge against medical advice and non-compliance with the medication regime. I accepted this expert view.

142. By the time of his death, what had initially been an approximately 2cm ulcer of the duodenum (the small intestine) had grown to a gastric ulcer that was approximately 5 x 6.5cm – indicating, in the words of Dr Vickers, a "massive expansion" of the ulcer which destroyed normal anatomy between the stomach and duodenum. This ulcer was the largest benign ulcer that Dr Vickers had encountered in his career.

143. The submissions of Counsel Assisting at the end of the inquest was that a number of factual findings ought to be made. I will address each of these in the order that they were raised, and have grouped some together under general propositions made. These matters go directly to the issue of how Simon died in custody in a 24-hour surveillance cell from a treatable condition. Further, the time of his death is unknown, and by the time he was located deceased it appeared he had been deceased for some time.

## CONSIDERATION OF ISSUES

### *Simon's history of gastrointestinal conditions evident in Justice Health records*

144. Simon had had a prior admission to custody the same year of his death, in January 2021. At that RSA conducted on 10 January 2021, Simon gave a history of blood in his stool, and that he had had, 6 weeks earlier an endoscopy in Wollongong Hospital due to the gastric ulcer. Given his reported history of gastric ulcer, the on-call GP was consulted, and Pantoprazole 40mg was prescribed for Simon until he could be reviewed.

145. Simon's reporting of this history of gastric ulcer on the early admission to custody prompted Justice Health staff to issue requests for information from Shellharbour Hospital and Wollongong Hospital, and records were produced by both. The records confirmed Simon's account of suffering from a gastric ulcer, having experienced melaena, and having undergone a transfusion. The records also indicated that Simon had been prescribed an oral dual antibiotic therapy, but had discharged himself against medical advice before completion of the full course.

146. This was a missed opportunity of Justice Health to have a thorough knowledge of and background to Simon, this is particularly so when he was eventually determined to be a mentally ill person, and thus more vulnerable.

147. I am satisfied on the evidence that this should have occurred in the normal course of initial investigation. Much of this information was available from Justice Health's own internal system that was not accessed.

148. I accept that the information was available to Justice Health, and would have been able to have been identified if they had regard to their own records, which would have been an appropriate and reasonable practice in these circumstances.

***On admission, Simon's medical history should have prompted medical review and treatment***

149. The purpose of the RSA is to identify health problems on entry to custody, make referrals and ensure ongoing assessment and management. It is ordinary policy for an RSA, to be completed within 24 hours of a patient entering a correctional centre. In Simon's case, that RSA was not completed until 28 August, one week later given Simon had been too mentally unwell to participate in an interview.

150. Between his admission on 21 August and the completion of the RSA on 28 August 2021, Simon had been displaying behaviour described as aggressive, agitated, elevated and disinhibited, and he was subject to an RIT Management Plan. He was also refusing to comply with clinical examination, including having his temperature taken. I accept that on the evidence Simon was already presenting as an inmate who may have had difficulty expressing himself, and looking after himself and addressing his physical needs.

151. On 27 August, Dr Hearps assessed that Simon had a schizo-affective disorder, with features of elevated mood, disorganised behaviour and persecutory delusions. Simon's acute mental illness would have had the effect of limiting his capacity to understand his own health needs, articulate symptoms he may have been experiencing, and communicate or advocate for his own health requirements.

152. Dr Quilty has expertise in caring for vulnerable and complex patients. In his opinion, in the absence of a medical history self-reported by Simon, a clinician should endeavour to conduct a clinical review of Simon at least by reference to the available notes of Simon's medical history, as well as physical observations of him.

153. In Dr Quilty's opinion, in light of the physical appearance of Simon, which was at least "very thin" if not obviously malnourished, the "logical next step" when Simon was unable to participate in an RSA was for a clinician to review the available notes and determine whether there were factors to explain why he was so thin. Having regard to the records in the possession of Justice Health, had even a paper review of Simon's medical file been undertaken at or shortly after his admission, his history of gastric ulcer would have been revealed.

154. It was the opinion of Dr Quilty that recurrence of the ulcer should have been recognised, from the records, as both possible and potentially catastrophic. His low body weight should have been treated with more alarm. Dr Vickers similarly gave evidence that, given Simon's self-discharge in November 2020 and the absence of evidence of sustained Pantoprazole use, he would have assumed that the helicobacter infection had not been eliminated and treated Simon accordingly.

155. Both Professor Vickers and Dr Quilty considered that pathology blood tests were indicated as at the date of Simon's admission. This would likely have included a full blood count, to determine if he was losing blood from the ulcer and becoming anaemic, as well as the "standard panel" of a white cell count and inflammatory markers, and a renal function and a liver test. It is possible that anaemia would have been revealed.

156. Both doctors also agreed that Simon, at the point of admission, required a prescription for Pantoprazole. Dr Vickers would also have commenced Simon on another course of dual antibiotic therapy for the eradication of the helicobacter pylori infection, even without a confirmatory breath test. Dr Vickers also accepted that he has particular expertise in this area.

157. It was accepted by Dr Quilty that Simon presented as a complex and difficult case. Dr Quilty said in evidence "the complexity of unpeeling his [gastrointestinal disease] history from his psychiatric illness" meant that he required complex case management from the day that he arrived, and indeed likely needed to be transferred to a hospital setting as soon as he was admitted.

158. Simon's medical history was not reviewed during his admission in custody, and therefore his gastric ulcer was not suspected or considered.

159. In December 2023 Justice Health updated their policy "1.255 – Health Assessments in Male and Female Adult Inmates". In light of that amendment, it appears this policy would have assisted Simon greatly, and it is a very positive policy amendment.

160. That policy inserted:

    a. "In circumstances where the patient is non-communicative or is acutely unwell, mentally unwell or under the influence of a substance or where information received during the assessment is inconsistent with any active or inactive PAS alerts or health conditions, the RN or EN should undertake a review of any recent electronic or hard copy medical records held by Justice Health NSW in relation to the patient. Should the hard copy volumes not be in the health centre, a PAS appointment must be made for a review when volumes arrive."

***RSA failed to identify Simon's known history of gastrointestinal conditions***

161. The RSA was completed on 28 August 2021, Justice Health RN Deanne Wood answered "No" to the prompt "History of Gastrointestinal Conditions." That answer was incorrect, as accepted by Ms Wood in oral evidence as being so.

162. It is appreciated that RN Wood was conducting the RSA under challenging circumstances. In August 2021, MRRC had become the hub for all COVID-19 positive cases. There were many sick patients and a shortage of nurses. The environment was described in evidence as chaotic.

163. RSA interviews were being conducted in holding yards in the reception area or through cell doors. Nurses did not have access to computer, but recorded patient's answers to questions on a paper copy of the RSA form. They were then required to enter that data into the Justice Health Electronic Health System, or JEHS.

164. Despite recognising these challenges, the evidence reveals that Ms Wood's completion of the RSA was deficient in certain material respects. Most of these were accepted by Ms Wood in her evidence:

    a. Ms Wood accepted that when she entered Simon's answers into the online RSA form, she should have, or in fact did, become aware of the health

conditions of melaena and gastric ulcer, which had been pre-populated into the RSA form due to his January 2021 admission.

b. Ms Wood agreed that she should have examined the clinical records available on JHeHS, and agreed that had she examined those records, she would have discovered Simon's history of Helicobacter Pylori infection, melaena, haematemesis and weight loss, and that he had been prescribed pantoprazole. She would have discovered that he had discharged himself from Wollongong Hospital against medical advice.

c. Ms Wood said that had she been aware of those matters, she would not have selected "no" to history of gastrointestinal conditions.

d. Ms Wood accepted that, given Simon's mental health and general presentation, she ought to have had cause to doubt the reliability of Simon's denial of having no active gastrointestinal symptoms.

165. Ultimately, Ms Wood conceded that she did not review Simon's medical record, and that she answered "no" to the question about history of gastrointestinal conditions simply on the basis that he was not reporting any *active* gastrointestinal symptoms.

166. Ms Wood accepted that had she become aware of his history, she would have moved to place Simon on the PAS waitlist for a chronic disease screen; put Simon on the waitlist to see a GP and contacted a GP to determine whether Simon required prescription of a PPI such as pantoprazole. I accept that if that had occurred, any reasonable GP would have prescribed him with pantoprazole.

167. I note that Ms Wood was very helpful in her evidence. Her upfront acceptance of the shortfalls of the review were extremely helpful to the proceedings. I should note that the system does require reliance on individuals within it. The role Ms Wood had of intake nurse is a difficult one, and she is subject to many pressures, particularly in the time of COVID. She noted in her evidence that she was incredibly busy and navigating new chaotic conditions, and she noted that there were a lot of sick patients in the centre. There was also a significant number of sick staff during that period, creating staffing shortages among Justice Health staff.

168. There were numerous different procedures in place, such as the location of the RSA, which was being done in the holding yards in the reception area, or through

the cell door through the hatch. She did not have access to a computer if she was completing a RSA in those circumstances as it was competed. She recorded her answers on paper. In the circumstances she could not do a physical assessment. She didn't have a specific recollection of Simon's RSA.

169. The system is one that should have checks and balances, to ensure that human error, as will always occur, have the opportunity to be clarified or identified. This was but one of the opportunities that were missed in relation to Simon, and I make no criticism of Ms Wood, but extend to her gratitude for performing the difficult task of assisting the inquest in the manner that she did.

***Timely and appropriate medical intervention by JHFMHN (including PPI, Pantoprazole) could have avoided Simon's death***

170. Proton pump inhibiters prevent gastric acid secretion, and gastric acid is the primary driver of further ulceration once the helicobacter has triggered the ulceration process. Dr Vickers gave evidence that it would take about just 3 or 4 days of use of Pantoprazole to cover the ulcer with a film of fibrines and commence the process of fibrosis. It would take about 10 days for the fibrine coat to form some sort of molecular adhesion. Dr Vickers gave evidence that with five days of reliable pantoprazole use he would be satisfied, on the balance of probabilities, that Simon would have survived. Four days he described as "borderline" but possible, while three days as "probably not."

171. On the evidence of Dr Vickers, which I accept, if Simon had commenced on Pantoprazole even as late as 14 or 15 September 2021, it is probable that his death would have been avoided.

172. On 16 September 2021 the evidence disclosed at hearing clarified that a telephone order of Pantoprazole was made by Dr Mica and placed by RN Shaun Dwyer. The notes indicate that that was prescribed to treat symptoms of reflux, rather than because any person had become aware of his history of gastric ulcer disease.

173. As a result of the location of this late evidence, a statement was obtained from RN Dwyer who was unable to shed any meaningful light on the circumstances in which he came to place a telephone order for Pantoprazole.

***Timely transfer to hospital by 3 September 2021 could have avoided Simon's death***

174. On 3 September 2021 Dr Hearps assessed that Simon was a "mentally ill person" for the purposes of the *Mental Health Act*. Dr Hearps concluded that care of an appropriate kind for Simon's mental health needs was not available in a custodial setting. This was critically important evidence in the proceedings. Dr Hearps gave evidence in a caring and considerate way. He was working within a system in CSNSW, and did what he could in the circumstances. In the community, if detained in the same manner, Simon would have been immediately transferred for assessment in an emergency department, and likely, based on the evidence which I accept from Dr Hearps that Simon was a mentally ill person, he would have then been transferred to a prescribed mental health facility. It is not the same treatment that Simon received in custody.

175. If Simon had been transferred to a hospital, I accept that he would have been subject to monitoring by health care professionals with clinical observation skills, rather than custodial officers.

176. There is no dispute that CSNSW Officers do not provide clinical care. Remote camera monitoring by custodial staff involves watching multiple people across multiple screens, and the main focus of the observations is on behaviour patterns that require intervention, such as attempted hangings, self-harm behaviour disruptive behaviour or flooding their cells.

177. If treated in a hospital, Simon would have been treated therapeutically. He would have been subject to regular observations, including the taking of his temperature, pulse, respiration and blood pressure, likely every 4 hours. As Dr Sullivan described it, "a doctor and nurses are entering the room, they're laying hands on the patient, they're physically assessing them." Simon's clear physical decline likely would not have gone unnoticed in a hospital environment.

178. The hospital environment also would have increased the likelihood of compliance with medication. The medical notes reveal intermittent compliance with medication prescribed to him. In this case, prescription of pantoprazole may not have had the desired effect without accompanying assertive treatment of his mental health. Once Simon was no longer floridly psychotic and thought disordered, the evidence supports the proposition that he likely would have

voluntarily accepted treatment of his gastric ulcer, as he had done in hospital admissions in the past.

179. I accept as submitted that had Simon been transferred to a hospital on or shortly after 3 September 2021, Simon's death would likely have been avoided. Once in a mental health facility he would have received appropriate medical care, which likely would have exposed the underlying condition that he suffered.

***Simon required urgent transfer to hospital by 17 September 2021***

180. The position of Counsel Assisting was that Simon's ongoing physical decline should have resulted in an urgent hospital transfer. There were also some indicators of his decline in medical and custodial records. These include reports that he was in pain, emaciated, had vomit in his cell, and had self-reported a history of blood in his stool.

181. But, perhaps given that his physical decline was missed by both Justice Health and Corrective Services staff, the most compelling evidence of Simon's physical decline comes from objective evidence, including CCTV footage from Simon's cell, and the audio recordings of the knock-ups. It was very difficult watching the video of the physical state that Simon was in close to his death. It showed incredible strength and courage for his family to remain and watch that footage in court.

182. Perhaps the distressing visual evidence viewed was eclipsed only by the audio evidence. Which again his family sat and endured. The audio from Simon's knock-ups were tragic in hindsight. In one audio recording from 17 Septemer, Simon requests a blanket, telling the CSNSW officer that "it's really cold". He asks repeatedly for water, which may be a sign of sepsis or a sign of dehydration. During knock-ups on 18 September, Simon begins to report shortness of breath and difficulty breathing. He is heard to be pleading.

183. It is important to describe the CCTV footage of Simon's final days. The Court watched two videos from 17 September, showing Simon naked and extremely thin. In one video, he was clutching at his stomach, was unable to maintain an erect posture, and needed assistance walking from the shower to his cell. In another video, Simon fell over in his cell, and needed to hold onto the toilet or cell

bars to stand. Dr Quilty and Dr Vickers identified that they could observe indications that Simon was in pain.

184. Footage of Simon collapsing and falling over in his cell was played, including footage as early as 10 September. The video footage of Simon's physical state on 17 September was played to both Dr Quilty and Dr Vickers during the course of their evidence. From this they each indicated that what they observed should have resulted in Simon urgently taken to hospital. Dr Quilty said that if he had seen Simon in a remote clinic, he would have initiated a medical evacuation to a hospital with access to gastroscopy, even without the benefit of the medical history. Dr Quilty was very troubled by the physical state Simon demonstrated in the footage.

185. There is to be no adverse finding against any individual doctor or nurse for failing to recognise the need for Simon to be transferred to hospital. It is not possible to attribute to any one person the knowledge of Simon's presentation that the Court viewed. However, the fact that no one observed Simon's dramatic physical decline is evidence of a significant collective and systemic failure to properly observe and care for Simon.

186. The cumulative failure was the result of the compounding effects of the previous failures in Simon's care. His mental illness and consequential behavioural disturbances had a tendency to overshadow physical health problems. There is no doubt that he was a difficult inmate, with unpredictable and unpleasant behaviours at time. CSNSWaff appeared to have no understanding that he was a mentally ill person. At least one officer indicated that he would have treated Simon differently had he understood this distinction.

187. Dr Vickers and Dr Quilty observed this to be a bias present across the whole medical system, as opposed to something unique to the custodial environment. As Dr Vickers pithily stated, "people seem to forget that psychiatric patients get diseases and medical admissions just as frequently as you and I."

188. Dr Quilty noted that a person's psychiatric condition may make it difficult to empathise with the experience of suffering. This is support for the fact that it was necessary that Simon make his way to a hospital for urgent treatment of his psychiatric illness.

***Surgical intervention and intensive care at hospital on 17 September 2021 could have avoided Simon's death***

189. There was a difference of opinion between Dr Quilty and Dr Vickers' medical opinion as to how Simon's gastric ulcer had likely progressed by 17 September. Dr Quilty was confident that Simon's gastric ulcer had perforated by 17 September, and considered it may have perforated as early as 15 September. Dr Quilty made reference to his experience in remote regions of the Northern Territory with treating younger people who attended with delayed presentations for perforation, who had a higher threshold for coping with perforation than older people with the same condition. I preferred the evidence of Dr Vickers on this point, given the nature of his speciality, and the fact that this was a reflection on an unseen patient. He was unsure whether Simon's gastric ulcer had perforated by 17 September. Having regard to Simon's apparent pain, Dr Vickers thought it possible that Simon had experience a possible micro-perforation of the ulcer and some early peritonitis. However, he considered that the more significant perforation which led to Simon's death was likely within hours of his actual death. He considered that the process leading to Simon's death was likely a rapid one, involving direct perforation of the ulcer into the liver and rapid septicaemia.

190. In either event, had Simon been taken to hospital, both Doctors did agree that it was likely that he would have undergone a laparoscopy followed by an emergency laparotomy when the size of the ulcer was revealed. Simon would need to have been managed in intensive care. Both experts expressed the view that, had Simon received this medical intervention on 17 September, Simon would likely have survived.

191. It is more difficult to say, as a matter of probabilities, that Simon would have survived if medical intervention only commenced after 17 September. However, the evidence of both experts was compelling on this point, that is that given Simon was a 41-year-old man, everything possible would have been done to save his life. On that basis I accept that Simon lost the chance to be treated and possibly saved even at the later time of 17 September 2021.

192. Dr Vickers mentioned the other complications that can arise as a result of late intervention, in relation to ongoing surgical intervention, or other physical illness, however, he should have been afforded at least the opportunity of survival.

193. Counsel for Justice Health, Mr Harris said that this position is the focus of the treatment was on mental health, given his severe behavioural disturbance, and the need to provide involuntary mental health treatment, because in effect he would not ordinarily comply with physical health treatment while mentally unwell.

194. He also noted the psychiatric symptoms masked the physical ones. Some of his complaining would have been attributed to a behavioural issue linked to mental health instead of reflecting his underlying serious physical illness. Mr Harris noted the failure to look back over Simon's records, which was another reason Simon's physical needs were not recognised.

195. Further it was submitted that there were no complaints about abdominal pain or gastrointestinal symptoms. He had been in the community for seven months since his last period of custody, and didn't receive any treatment for his peptic ulcer disease.

196. Mr Harris also noted the significant impact of COVID at the time of Simon's incarceration and the impact on waiting times for meant health access and general treatment. Finally, he noted that Justice health Staff have only intermittent access to inmates, unlike a hospital.

197. Mr Harris raised that in the seven months in the community he had seven attendances at hospital and four admissions. No treatment was commenced for peptic ulcer at that time, even at a review occurring 6 days prior to Simon entering custody. Mr Harris uses this as examples of the complex presentation faced by other health professionals with Simon.

198. Mr Harris also submitted that Simon appeared to be non-compliant with treatment in the community, and that complicates findings about his likelihood of survival. He also was not reporting physical symptoms and as such if he had reached the hospital it might not have been the case that his underlying physical injury would have been identified.

199. This is support for the proposition that Simon should have been hospitalised as soon as possible to address his mental health, which would have given him the chance of being able to identify his illness and alert others. However admission to psychiatric facility would have brought Simon closer to proper medical attention through blood tests and other investigations, and even just having medical

practitioners assigned to his personal care would have given him a good chance of having his symptoms recognised.

200. Attention is drawn to Dr Vickers in his report "there's an outside possibility but not probability that had he been referred to hospital in the days prior to his death Mr Cartwright may have been salvaged." Further he said "extensive upper abdominal surgery and a total gastrectomy may well have been required, which itself would have had a significant post-operative mortality in a weakened individual". He also said "Referral to the hospital within the 72 hours of his death would likely have been too late and had resulted in a terminal event."

201. Although it was said that he did not resile from that in his evidence, he did clarify the evidence, and I am again satisfied that what Dr Vickers ultimately gave evidence of was that although the overall outcome is difficult to gauge in those critical days, all efforts would have been made to save his life.

***Failure of JHFMHN to undertake food and fluid intake monitoring***

202. At his review of Simon on the 17th, Dr Hearps recorded in his plan for Simon that there be monitoring of his food and fluid intake. In oral evidence, Dr Hearps said that he believed that such monitoring could and would be undertaken. He said that he entered the requirement onto a "clinic tracker", and it was his expectation that somebody in the primary health nursing team would create a chart that would allow for fluid and food monitoring. The clinical tracker prepared by Dr Hearps was tendered and confirms that the entry was made.

203. The evidence of Dr Nicholls, the Acting Executive Medical Director and Clinical Director of Primary Care medicine with Justice Health, is at odds with Dr Hearps' expectation. His evidence was that the only place he was aware that you can do monitoring of that nature is an acute hospital ward situation, or for somebody who might be on a hunger strike. He characterised Dr Hearps' request as a "general observational request" rather than a "formal form or requirement". This was not the intention of Dr Hearps.

204. While only a few days passed from 17 September to Simon's death, there was no indication that anybody was recording Simon's food and fluid intake, or that there was any realistic mechanism or system by which that was intended to occur.

205. While it may be that the cause of the problem was simply that Dr Hearps' clinical tracker was not properly reviewed and actioned, the evidence of Dr Nicholls would suggest that a more systemic problem exists. That is, there would appear to be a concerning disparity between what was requested, and what could have been provided. The state of the evidence on this topic is relatively limited, however, it is clear that there needs to be some review of Justice Health's policy or mechanisms to ensure that food or fluid intake observations occur if they are requested, and that doctors are not making recommendations that are, in effect, futile.

206. If food and fluid monitoring is required but is not a service that can be provided in prison, then it may highlight the need for a person to be transferred to hospital.

***Failure to provide adequate psychiatric care and timely transfer to the MHSU***

207. Simon was admitted to custody on 21 August, and first seen by psychiatrist Dr Hearps on 27 August 2021. At the first review by Dr Hearps, Simon was determined to be suffering from a mental illness, but not to satisfy both limbs of the test in s 14 of the *Mental Health Act*. That is, although mentally ill, involuntary treatment of Simon was not at that time deemed necessary. The principal factor that led Dr Hearps to this conclusion was that, despite his mental illness, Simon expressed a wiliness to voluntarily take medication.

208. Although he did not schedule Simon, Dr Hearps determined at that review that the minimum level of care that Simon required was in the Mental Health Screening Unit and placed him on the waitlist accordingly. While that Unit would ultimately have been insufficient to provide appropriate care for Simon's mental health needs, it would nonetheless have represented an improvement on his placement in an assessment cell in Darcy. Among other things, it is an area of the prison with a greater ratio of mental health staff to inmates, and Simon would likely have received daily reviews by a mental health nurse.

209. At the time of Simon's death, over three weeks after he had been placed on the waitlist, he had not yet been admitted to that unit.

*On 3 September 2021, Dr Hearps correctly assessed: that Simon met the definition of a "mentally ill person" for the purposes of s 14 of the Mental Health Act 2007; that*

*Simon required involuntary care; and that care of an appropriate kind was not available in the custodial setting.*

210. The totality of the evidence supports Dr Hearps' assessment on 3 September and on all accounts, it was the correct one. Dr Sullivan's opinion, on review of the records, was that Simon was experiencing a severe mental illness. Dr Sullivan described his mental illness as acute, florid and pervasively affecting Simon's functioning, such that it would have been obvious to even a lay person that he was unwell and required treatment. Dr Sullivan also considered that the severity was such that Simon was likely suffering, distressed, and may come to further harm if not assertively treated. Dr Sullivan indicated that his mental illness by 3 September was unlikely to spontaneously resolve. Dr Sullivan described Simon's state as a "psychiatric emergency" that required timely treatment.

211. The therapeutic care that Simon urgently needed was only available in a hospital. Had Simon been transferred to a hospital, he would likely have received an involuntary injection of a benzodiazepine, a medication that has both an anti-psychotic and sedating effect. This would have offered Simon some immediate relief from his suffering.

212. However, between 3 September and the date of his death, a bed never became available for Simon at Long Bay Hospital.

213. There was evidence given of the waitlists for Long Bay Forensic Hospital that were considered at the bed demand meetings. I make no criticism of the decisions made in those meetings as to the priority afforded to Simon. The evidence highlighted the number of severely unwell people in Simon's position, on a waitlist.

*Given the severity of his symptoms, it was unacceptable that a transfer of care did not occur urgently. As a result of that delay, Simon received a level of care that fell well below the standards of what would be expected in the community.*

214. This was a proposition with which all psychiatrists who gave evidence, including both Dr Hearps and Dr Ellis from Justice Health, agreed.

215. In Australia, all individuals have a right to access healthcare appropriate to their needs regardless of their legal status as prisoners. Further, the principle of

equivalence holds that prisoners should enjoy the same standards of healthcare as are available in the community through the public health system.

216. The evidence in the inquest was that had a person attended an emergency department, the standard for admission across Australia is that definitive treatment should be instigated within four hours. In Dr Sullivan's experience, it would be rare that a person requiring involuntary care would be delayed for more than 24 hours. Dr Sullivan explained that while there were cases where people remained in an Emergency Department for 2-3 days, these are regarded as "system failures."

217. Simon, by contrast, waited in Darcy for 17 days from the time he was scheduled. That delay is a gross systemic failure.

218. In the opinion of Dr Sullivan:

> "Given the severity of his symptoms, it is unsatisfactory that people who are so unwell cannot be transferred urgently. I consider that if any acute physical health problem presented with a commensurate level of acuity and distress, it is unimaginable in Australia in that treatment would not occur urgently or that a person would be placed in an appropriate physical health setting to receive urgent treatment within days, rather than weeks or months."

219. Orally, Dr Sullivan expressed that most Australians would be "horrified" to realise the delay that mental health patients in prison may experience before they're transferred to a place where they can receive appropriate care. Not only did Simon not receive the care he needed, but he was held in a counter-therapeutic environment. He was in a cold looking, stark, bare cell, with no soft surfaces, limited blankets, with lights that remained on through the night, in an environment that was loud and chaotic.

220. I note here that the footage of that cell as he sat alone, holding onto himself, knowing the pain that he may have felt, the mental anguish he may have been experiencing was something that was very difficult to watch.

221. This environment must have added to the inherent distress of a severe and untreated psychiatric illness, that Dr Quilty described as "mental illness torture".

222. Dr Quilty added that, certainly towards the end of his life, the combination of his mental and physical illnesses meant that he was likely in pain, confused, delirious, and (Dr Quilty presumes) scared.

*An urgent medical transfer to an external hospital could have been achieved using the power in s 24 of the Crimes (Administration of Sentences) Act 1999. Justice Health ought to have considered recommending a s 24 medical transfer.*

223. The method that was being used to facilitate Simon's transfer to Long Bay Hospital was s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.

224. This is a legislative mechanism specifically addressed to persons with mental health impairments, that provides for the transfer of persons in correctional centres to a mental health facility. However, s 86, at that time, only permitted the transfer of male inmates to two mental health facilities being Long Bay Hospital, which is both a prison and a gazetted facility, and the Forensic Hospital, where there is a security protocol between the Commissioner of Corrective Services and the Secretary of the Department of Communities and Justice.

225. Where beds are not available in those facilities, a s 86 transfer cannot occur, and a person remains on a waitlist.

226. There is a second legislative mechanism that exists, being s 24 of the *Crimes (Administration of Sentences) Act*. This provision provides for the Commissioner of Corrective Services or the Governor of a Correctional Centre to make an order for a patient to be transferred to an external public hospital.

227. The order can be made if it is "necessary or desirable" for the patient to receive medical attention at a hospital.

228. Section 24, Crimes (Administration of Sentences) Act 1999 provides as follows:

> **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.

229. Whereas section 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* 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.

230. These provisions are from two different Acts, one empowering the Secretary to order the transfer, the other empowering the Commissioner to make the transfer. In my view there is no bar to the use of section 24.

231. The process, in practice, is:

a. Justice Health produce paperwork providing advice than an inmate needs to be transferred.

b. Corrective Services will act on that advice and prepare the relevant order requiring transfer.

c. The medical transfer unit of Corrective Services will organise and execute that transfer.

232. This is a process that is routinely used to facilitate the treatment of inmate's physical health conditions, when they can't be provided with the care they require in a custodial facility.

233. However, in the experience of both Dr Ellis and Dr Hearps, who had 24 and 15 years' experience providing psychiatric care at Justice Health respectively, it was and is never used in order to facilitate the urgent care of a psychiatric patient.

234. As Dr Sullivan expressed in oral evidence, if the salient characteristics for determining whether a transfer should happen are the level of distress, or the severity of the condition, or the need for urgent treatment, then there is no rational basis to distinguish between physical and psychiatric health conditions.

235. Dr Ellis, speaking for Justice Health, indicated that there was no legislative barrier to the use of s 24 to allow inmates to receive necessary or desirable psychiatric care. This must be correct. In particular, while the s 86 mechanism exists, one would not construe it as covering the field and excluding the clear beneficial purpose of s 24. There is no written policy that would prevent the use of s 24.

236. The evidence of Corrective Service was that if there had been a recommendation from Justice Health to transport a patient for mental health treatment, they would have ensured that recommendation was complied with without looking behind the recommendation.

237. Accordingly, I conclude that this was a procedure that was available to facilitate Simon's urgent transfer to hospital, notwithstanding it wasn't used in practice.

238. Given that Simon was experiencing a psychiatric emergency on the expert evidence before me, and there were no beds available within a reasonable time to treat to him at the time he needed it, I conclude that the power in s 24 could have been used.

239. Specifically, Justice Health ought to have made a recommendation to Corrective Services for that transfer.

240. Section 24 places a resource demand on Corrective Services, who would have required staff to transport Simon to hospital, and likely at least one but perhaps more officers to remain in charge of Simon while in hospital.

241. I accept that there are better solutions to provide appropriate mental health care in prison than reliance on s 24, including the matters spoken about by Dr Ellis in his evidence, such as continued efforts to develop security protocols with Local Health Districts to facilitate transfers under s 86 of the Act; and continued expansion of bed space at forensic hospitals, to properly cater for custodial needs.

242. I accept also the issues raised by Dr Ellis of the impact this would have on the public Emergency System, the extra pressure and need for resources this would place on Correctives Staff. However, the evidence was that the waitlist is generally not the size seen when Simon was on the waitlist, nor is such a considerable delay usual, and if indeed it is the rarer event that arises, the section could be used sparingly in the interests of providing proper and appropriate care when Long Bay and the Forensic Hospital cannot assist.

***Availability of psychologists/mental health support in custodial settings***

243. In addition to a psychotic mental illness, Simon was suffering from a personality disorder, which Dr Sullivan considered included borderline, narcissistic and antisocial traits.

244. Dr Quilty described the diagnosis of a personality disorder as “a label that is often picked up within acute healthcare settings in a prejudicial way, where the person is often treated as if it is their fault.” He considered that the diagnosis can label a person, and significantly damage clinical relationships with clinicians that don’t know the person well, right at their time of need.

245. Dr Sullivan similarly described it as a pejorative and stigmatising diagnosis, that can be a barrier to them receiving the care that they need. It may also lead to clinicians missing symptoms of other mental illness.

246. In Simon’s case, this effect likely had a greater impact in relation to his treatment prior to his admission to custody, noting that Dr Hearps correctly diagnosed him as also suffering from a psychotic disorder.

247. To some extent, the stigma of a personality disorder arises because of a belief that personality disorders are inherently untreatable. However, as Dr Sullivan explained, there are interventions available, principally psychological assistance. The evidence of Dr Ellis was that, due to a "legacy issue", psychologists are employed by Corrective Services, not by Justice Health. As he observed, psychologists have different roles when they're employed by correctional agencies, some of which are not therapeutic.

248. In Dr Ellis' opinion, there is not systematic support for people with personality disorders in custody, which is an "area that needs further development." He agreed that it was preferable that Justice Health had the ability to hire its own psychologists to provide a purely therapeutic or clinical service, without a correctional overlay.

***Failure to follow policy relating to access to water***

249. There is no evidence as to when water to Simon's cell was turned off, and whether it was ever restored, no record was kept. The Darcy Inmate Accommodation Journals for the period of 21 August to 19 September 2021. What is notable is the absence of any records in those journals of water being turned off to Simon's cell, or indeed any other cell. Simon's first knock-up asking for the water to his cell to be restored is at 4:11pm on 17 September 2021. At 11:31pm on 17 September, he tells the operator that his water has been turned off all day.

250. From his first request on 17 September and continuing through to 18 September, Simon is heard repeatedly, and with increasing desperation, requesting water. Across these calls, Simon can be heard saying, "Can you turn the water on", "Please can you turn the water on", "I need water", "I need about 4, 5 cups of water now."

251. While the initial purpose of turning off the water to Simon's cell may have been proper – namely, to prevent him from flooding his cell the evidence is that by the evening of 18 September the calls indicate that restoring his water was being used to bargain for improved behaviour. This can only be characterised as a correctional or punitive purpose, and I accept was therefore inappropriate. Even when Simon complied with the requests water was still not restored.

252. At 5:49pm on 18 September, after being told that officers “don’t have time” to turn the water on because they need to keep answering his knock-ups, a bargain is made with him that if he will be “quiet for ½ an hour” his water will be turned back on. Between 5:51 and 7:14pm, he was quiet. For nearly an hour and a half, no knock-ups were recorded.

253. At 7:14pm, he finally asks again, can you please turn the water on? But he is again told that they wouldn’t be “fixing it” until he behaves.

254. His last request for water, at 7:48pm on 18 September, is met with, “if you don’t behave like that we will.”

255. Ms Avery-Williams submitted that section 24 is not open to be used, given the existence of section 86 of the Act.

256. It is of course preferable that section 86 transfers occur, but there is nothing precluding the transfer. That was the evidence in the proceedings, and section 24 and 86 are two separate mechanisms for transfer, leaving section 24 as another mechanism for transfer. I was not provided with any other assistance on that point, other than a suggestion that I would interpret the section that way, and that statutory interpretation would lead to the result that a transfer under section 86 is available for a mentally unwell person to a mental health facility and section 24 could not be used in that circumstance.

257. Section 86 provides a direct referral to a designated mental health facility, whereas transport pursuant to section 24 would result in an ED presentation and separate assessment, but this does not prevent that as an option.

258. The submission was made despite the fact that because he wasn’t being properly treated for his mental illness which was masking his significant and indeed fatal health condition, from which he died, he had to remain until a bed became available.

259. Further a submission was made that I could only be satisfied that there is no evidence that the water was ever restored to Simon. However, the last call we have from Simon available on the knock-ups was 7,48 pm on 18 September, when he is him continuing to beg for the water to be restored to him.

260. There was no proper documentation of the water issue through CSNSW. I accept given that Simon continued to request water that when he needed it, it was not restored. On balance I accept the evidence before me that it was not restored.

*Policies in relation to turning water off to an inmate's cell, to the extent they existed, were not followed.*

261. Director Wilkinson gave helpful evidence, and noted that the decision to turn water off to an inmate's cell is not governed by any formal policy or procedures. However, at some time in 2021, after he became Governor, he introduced a requirement that, unless recommended by a RIT or Justice Health, the disconnection of water should be approved by the Functional managed and documented in the relevant Wing Accommodation Journal. There is no evidence in this matter of approval being sought from a functional manager. To the extent such a policy existed at the time of Simon's death, it does not appear to have been understood by Corrective Services staff.

262. The evidence of Senior Correctional Officer Dean, the A-watch supervisor, was equivocal as to whether he expected that the turning off of water would be recorded in the accommodation journal and was even less sure that there would be a record of water being turned back on. The evidence of Senior Correctional Officer Dorrans, who was the C-Watch officer-in-charge, was that he was unaware whether water to Simon's cell had been turned off; unaware of where he would find that information; did not expect that it would be documented in the accommodation journal.

263. In one knock-up call at 11:31pm on 17 September, the officer who answers is seemingly unaware that Simon's water has been turned off, but tells Simon, "they can't have it off without any reason buddy."

264. If Simon's water had not been restored any time on the evening of 18 September, it is likely that Simon would have been suffering from severe dehydration by the time of his death. This would have been on the background of a severe psychiatric illness, and the early stages of peritonitis and septicaemia.

265. As Dr Quilty expressed it, it is never reasonable to deny any human being access to water.

266. As explained to the family I now insert a summary of the knock up calls that set out a summary of what was said to Simon when he contacted Corrective staff in the days prior to his death.

| Call time and date | Call length | Summary of call |
|---|---|---|
| 17/9/2021<br>1:12am | 00:26 | CSNSW: Medical?<br>Simon: Please can I have a sandwich.<br>CSNSW: What happened mate?<br>Simon: Please can I have a sandwich. I haven't eaten in 2 days. Please.<br>CSNSW: Alright mate I'll come and see you on the next round.<br>Simon: PLEASE. |
| 17/9/2021<br>1:28am | 00:17 | Simon: "Please, please, can I have a blanket?"<br>CSNSW: "Are you going to flood your cell?"<br>Simon: "Can I please have a blanket?"<br>CSNSW: "Are you going to flood your cell again?"<br>Simon: "No"<br>CSNSW: "I'll pass it onto Darcy staff." |
| 17/9/2021<br>1:41am | 00:53 | Simon: "Please can I have a sandwich"<br>Simon: "Please can I just have one sandwich"<br>CSNSW: "Your family?"<br>Simon: "Please can I just have one sandwich I haven't eaten in over two days"<br>CSNSW: "Everyone is asleep, its 2 o'clock in the morning, no food to give you"<br>Simon: "Please"<br>CSNSW: "I've already told the nurse when she does your rounds, nurse will say if you can eat, not up to us"<br>Simon: "Please can I have a sandwich, how long" |
| 17/9/2021<br>1:42am | 00:45 | Simon: "Please can I just have a sandwich, I need it" (incoherent) |
| 17/9/2021<br>4:11pm | 00:31 | CSNSW: "Medical?"<br>Simon: Groaning noise.<br>CSNSW: "Can you pull that stuff off your camera, I can't see you mate."<br>Simon: "I will if you turn my water on".<br>CSNSW: "When you take that stuff off your camera I'll turn your water on". |
| 17/9/2021<br>4:44pm | 00:29 | CSNSW: Medical?<br>Simon: "Can you turn the water on please"<br>CSNSW: What for?<br>Simon: "I need the water on, need to flush the toilet and have a drink".<br>CSNSW: Is your cell clean?<br>Simon: "Yes".<br>CSNSW: Just wait a minute. |

| | | |
|---|---|---|
| 17/9/2021<br>6:36pm | 00:30 | Simon: "Two nights ago, the first night I came into the cell, the guy in the cell next to me flooded it."<br>CSNSW: "Don't worry about the guy next to you no one can touch you."<br>Simon: "Can you please turn my water on".<br>CSNSW: "If you stop knocking up I'll turn your water on".<br>Simon: "Thank you". |
| 17/9/2021<br>9:13pm | 00:17 | Simon continues to beg to turn his water on. "I need about 4 cups, 5 cups of water now". |
| 17/9/2021<br>11:13pm | 00:31 | Simon: “Can I have a blanket?”<br>CSNSW officer tells Simon to "hang in there" and she'll bring him a blanket after she finishes his lunch.<br>Simon: "It's really cold". |
| 17/9/2021<br>11:31pm | 00:10 | Simon asks for the water to be turned on again. |
| 17/9/2021<br>11:13pm | 00:37 | Simon asks for his water to be turned on again.<br>CSNSW ask him what happened to the water, he replies "I didn't do anything they just turned it off" (incoherent).<br>He pleads "get me water" (incoherent). |
| 18/9/2021<br>3:41pm | 00:41 | Simon: "to the lady in control about something I was willing to do for her when I get out of here. I don't have my Westpac card, the friend that I have, are you listening, sorry I'm just struggling". |
| 18/9/2021<br>4:46pm | 01:29 | Simon: "Sorry, I'm not well, just let me catch my breath…The thing is, I've got money in the bank. I've got money in the bank that I'm willing to give you".<br>CSNSW: “When the nurse does medication I'll let her know.”<br>Simon: (Incoherent) "Can I get down to the final thing? Sorry you don't have very good English I can't talk to you very well".<br>CSNSW: “I'll let the nurse know that you want to see her”.<br>Simon: “Now”.<br>CSNSW: “I can't”.<br>Simon: “I want her now”.<br>CSNSW: “Even if you go to emergency you aren't seen immediately, you have to wait”. |
| 18/9/2021<br>5:04pm | 00:24 | CSNSW: “Yeah?”<br>Simon: “Yeah its not about me its not about my troubles.”<br>CSNSW: “I can't hear you its breaking up. I'll come and see you.”<br>Simon: “You have to understand I'm struggling to breathe.” |
| 18/9/2021<br>5:09pm | 00:13 | CSNSW: “Medical?”<br>Simon: “Yeah um sorry just give me a sec, I'm standing in front- just give me a few minutes to breathe.” |

| | | |
|---|---|---|
| | | CSNSW: “You're not doing yourself a favour just go to sleep.” |
| 18/9/2021<br>5:12pm | 00:09 | CSNSW: “Okay if you want to spend the night sitting next to the toilet and pressing the button, go ahead.” |
| 18/9/2021<br>5:16pm | 00:14 | CSNSW: “Medical?”<br>Simon: “Please, please, just give me a chance, please.”<br>CSNSW: “There is stuff coming to the gaol and you can go and see the doctor anytime you like. Here you have to wait.” |
| 18/9/2021<br>5:44pm | 00:10 | CSNSW: “Medical?”<br>Simon: "Can you turn the water on"<br>CSNSW: “Just cover yourself under the blanket and no one will get you.” |
| 18/9/2021<br>5:45pm | 00:09 | Simon begs for the water to be turned on again, CSNSW replies telling him to hide under the blanket. |
| 18/9/2021<br>5:46p | 00:09 | CSNSW: “Yeah this is really entertaining actually.”<br>Simon: “CAN YOU TURN THE WATER ON.”<br>CSNSW: “Yeah keep buzzing up actually this is keeping me entertained.” |
| 18/9/2021<br>5:46pm | 00:08 | CSNSW: “Medical?”<br>Simon: “CAN YOU TURN THE WATER ON.”<br>CSNSW: Not at the moment.” |
| 18/9/2021<br>5:48pm | 00:16 | CSNSW: “Medical emergency?”<br>Simon: “Please can you turn the water on.”<br>CSNSW: “Can't leave this, if you keep buzzing up I have to answer the intercom.” |
| 18/9/2021<br>5:49pm | 00:13 | CSNSW: “Medical emergency?”<br>Simon: “PLEASE CAN YOU TURN THE WATER ON.”<br>CSNSW: “I don't have time to go over there and turn the water on because I have to keep answering because you're knocking all the time.” |
| 18/9/2021<br>5:49pm | 00:37 | Simon asks for the water to be turned on.<br>CSNSW: “Cartwright is that you? Cartwright listen. If you be quiet for half an hour and stop knocking up I'll turn the water on.” |
| 18/9/2021<br>5:51pm | 00:20 | CSNSW: “What do you expect from us?”<br>Simon: “I want my water turned on.”<br>CSNSW: “If you keep knocking up I can't turn the water on. I can't leave this place.” |
| 18/9/2021<br>7:14pm | 00:15 | CSNSW: “What is your 300th medical emergency for the night?”<br>Simon: “CAN YOU TURN THE WATER ON.”<br>CSNSW: “If you aren't knocking up so much I'll do it.”<br>Simon: “PLEASE.” |
| 18/9/2021<br>7:15pm | 00:10 | CSNSW: “Medical?”<br>Simon: “CAN YOU PLEASE TURN THE WATER ON.”<br>CSNSW: “Stop behaving in such a way.” |

| | | |
|---|---|---|
| 18/9/2021<br>7:48pm | 00:09 | CSNSW: “Medical?”<br>Simon: “Can you turn the water on please.”<br>CSNSW: “If you don't behave like that we will.” |
| 18/9/2021<br>10:56pm | 00:29 | Simon: “Can you talk to me?”<br>CSNSW: “What's up?<br>Simon: “It's the big flood. I'm getting set for the big flood, he's got something he wants, something doesn't go his way and then he floods…”<br>Call terminates. |
| 19/9/2021<br>3:41pm | 00:13 | CSNSW: “Cartwright?”<br>No reply. |
| 19/9/2021<br>5:30pm | 00:23 | CSNSW: “Hey mate, 37. Cartwright. Cartwright, wake up.” |

***Failure to adequately observe Simon in his 24 hour observation cell***

*The CCTV of Cell 37 in Darcy 1, where Simon was housed, was covered from approximately 9:00pm on 18 September 2021, until after Simon’s death.*

267. The critical findings in relation to this proposed finding are already admitted in the Serious Incident Report prepared by Corrective Services.

268. Detective Senior Constable Marshall was an exceptional investigator in this matter. The investigation of death in custody is an important yet time consuming role provided by police. If Detective Senior Constable Marshall had not undertaken the excellent investigation, which continued during the inquest, we would not have had the benefit of the following evidence on the last day of hearing: These are further matters that went unnoticed while he was in his cell under observation.

> Q. As a consequence of evidence given during the first tranche of this inquest you have since had cause to review that footage from 10 September until the date of Simon’s death on 19 September, is that right?
>
> A. Yes sir.
>
> Q. You have reviewed that footage with a view to identifying each occasion on which Simon slipped or fell in his cell, is that right?
>
> A. That’s right.
>
> Q. Your review of that footage was hampered by CCTV footage which was at times unable to be deciphered in circumstances where there was a substance on the camera, is that right?

A. That's right.

Q. And you were unable to see anything meaningful on 19 September 2021, is that right?

A. That's correct.

Q. Tell me if this is correct, aside from an occasion where Simon was seen to slip on water on 16 September and aside from the incident on 17 September which had already been identified during the inquest when it began in May, of the footage that was just played did that reflect each of the additional falls you have identified that Simon had since 10 September onwards?

A. It did.

## FURTHER FOOTAGE OF SIMON FALLING

269. On 10 September 2021 commencing at 7.29pm, a clip was captured by camera inside Simon's cell. The quality of this footage is affected by substance which is applied to the camera. In the footage Simon is seen lying on his mattress on the bed, he is seen to get up from the bed and make his way towards the toilet and 45 seconds into the footage he is seen to fall heavily backwards. Simon remains on the ground 4 minutes.

270. On the same day 10 September 2021 at 8.13pm, 34 minutes later. Simon is seen in this footage sitting on the toilet. Someone in PPE comes to his cell door about 1 minute and 15 17 seconds into the clip Simon is seen to place both his hands through the slot in the cell door. At 1 minute 24 the person in PPE is seen to depart. Simon's arms remain through the slot until he falls towards his left at 1 minute 39. A person briefly comes back into view before again leaving. Simon remains in that position for the balance of the clip,

271. The next fall is a fall captured by camera on 17 September 2021 at 8.39am. This is a different fall to that which had previously been identified on 17 September. In this footage Simon is naked; at the commencement of the video he is seen on his bed under a blanket. He removes the blanket and moves to sit on the toilet. He appears to speak to someone who is at the door. At 1 minute 21 into the clip he is seen to sway from his left to his right before falling off the toilet. From about 1 minute 35 Simon is seen speaking to someone at his cell door and that can be seen from the other camera angle. He remains talking to someone at his cell door

before returning to sit on the toilet and he remains sitting on the toilet either with his hands in 45 his lap or holding his head for the balance of the clip.

272. The next clip is the first of three falls captured on 18 September 2021 Simon has moved to a different cell. In this footage Simon can be seen to stand up from his bed, he moves towards the toilet where he is seen to stumble and fall backwards over the toilet.. Simon remains on the ground for about two minutes before returning to his feet.

273. The next footage is captured again on 18 September 2021 and it is three and a half hours after the previous fall, at 7.06pm. In this footage Simon is seen sitting on his bed, he stands, moves to the toilet where he sits for a short period and on his way back to his 20 bed he collapses. Simon remains on the ground for about two minutes before returning to his feet.

274. The next clip again is on 18 September 2021 at 8.49pm which is about an hour and a half after that previous fall. In this clip Simon is seen to stand up from his bed, he moves towards the adjacent CCTV camera before falling backwards. He gets up to his knees after falling and is seen again to lose his balance. He remains in that right lateral position on his side for approximately five minutes before getting to his feet and moving around his cell.

275. The report did not have the benefit of this additional evidence.

276. In particular, the Report acknowledges that:

    a. Simon covered the cameras in his cell just before 21:00 on the evening of 18 September 2021, such that there was no vision into the Observation/Assessment Cell 37 for a period of almost 24 hours.

    b. No remedial action was taken to clear the cameras across three consecutive Watches, or shifts, to clear the camera.

    c. CO Panuccio became aware it was covered at about 3:47pm, but made no effort to contact SCO Dorrans until 7:30pm.

277. The consequence is that the requirement for constant electronic monitoring in Simon's RIT plan was not, and could not have been, fulfilled.

278. The evidence was that if an inmate had covered their camera, the process that ought to have been followed was:

    a. contact inmate to request it be uncovered.

    b. an officer should then go to the door of the inmate's cell and attempt to negotiate with the inmate.

    c. Failing that, the matter should be escalated to a senior officer for consideration of whether immediate entry needed to be made to the person's cell for the purpose of clearing the camera.

279. It was Director Wilkinson's expectation, expressed in his oral evidence, that the camera covered at 9pm on 18 September should have been uncovered no later than 10pm – that is, approximately one hour later.

280. There was at least one opportunity on the morning of 19 September, when three officers entered Simon's room for the purpose of a welfare check, that the camera could have been safely cleared. Director Wilkinson's expectation was that if electronic monitoring could not be conducted in accordance with the RIT, physical observations would occur every 15 minutes.

281. The Serious Incident Report recommended that there be a review of local procedures related to Observation cell camera serviceability reporting, and more formalised practices related to accountability for remediation of off-line cameras. Director Wilkinson's evidence was that, in response to the SIR, MRRCs Local Operating Procedures were reviewed and updated. Those policies were annexed to his statement.

282. Director Wilkinson provided evidence of two other reforms relevant to the monitoring of inmates:

    a. First, from 27 October 2021, a specialised Transition and Assessment Cell Observations Suite commenced operations, to improve monitoring of at-risk inmates. It is staffed by two officers tasked with monitoring the inmates housed in Transition and Observation Cells, so that the burden is taken off the main control room and also the officers assigned to Darcy. This represents a significant improvement from the situation that prevailed in September 2021, when the evidence was that there was no dedicated observations officer on the A-watch shift.

b. Secondly, Corrective Services is currently trialling a proof of life monitoring system using a radar sensor that tracks an inmate's vital signs. Importantly, the sensor is hidden in the light fixture and capable of working even if covered, making it more resistant to tampering or interference from inmates. Director Wilkinson's evidence of this was promising and one of the recommendations is that Corrective Services continue exploring the future use of this system.

283. While the failure to clear and monitor the CCTV would otherwise have formed the basis of significant recommendations, in light of the reviews that occurred following the Serious Incident Report, I accept given the work already undertaken in this area that minimal recommendations are required about this issue.

***Breakdown of communication between CSNSW and JHFMHN regarding Simon's physical state***

284. In his statement dated 22 November 2024, SCO Dean provided evidence that between 9 and 9:30am on the morning of 19 September, he received information from CO Tekinder that she thought Inmate Cartwright looked unwell. CO Tekinder however, provided a statement to the effect that she was working in a different unit and had no interaction with Simon. Despite this being put to SCO Dean, he maintained that he had a "very high" confidence that he received that report. Without further evidence, it is difficult to resolve the difference in the positions between SCO Dean and CO Tekinder.

285. However, I accept that SCO Dean received a report relating to Simon's health on his own evidence. I accept SCO Dean reported that information to another Correctional Officer working in the MRRC clinic and asked that that message be passed on to a nurse. The incident report recording that this occurred was at 10:30am on 19 September.

286. There is no evidence from that point as to whether that message was passed on to, and received by, Justice Health. The two junior nurses that did see Simon on the 19th, being nurses Bishwokarma and Vora, were there only for the purpose of either delivering medication or conducting COVID checks, rather than responding to a medical request.

287. At 9:20pm on 19 September, about an hour after his death, a PAS waitlist entry was made by RN Thanjan indicating that Simon had noticed blood after opening his bowels for the past month. RN Thanjan had been working in Goldsmith Pod on that day, which makes it unlikely that he had any interaction with Simon, and no nurses other than Vora and Bishwokarma are seen on the CCTV attending his cell. RN Thanjan, in his statement, thought he may have entered Simon on the waitlist to see a nurse after processing patient self-referral forms, however Justice Health has confirmed that Simon had not completed any self-referral form.

288. On possibility is that Officer Dean's report was passed on to Justice Health earlier that day, but only processed later in the evening by RN Thanjan. However, there is a significant discrepancy between what SCO Dean said he reported, that Simon was losing weight, with what is recorded in the waitlist entry, that Simon was noticing blood in his stool.

289. It is ultimately difficult to pinpoint where and when the breakdown in the chain of communication between SCO Dean and Justice Health occurred. Whether the message was not received by Justice Health, or whether it was not actioned with due urgency, it is obviously a matter of concern.

290. Another missed opportunity was that SCO Dean did not pass the information about Simon's purported ill-health to either SCO Dorrans, the C-watch Officer-in-Charge, or CO Panuccio, the C-Watch observation officer. Mr Panuccio was the officer who was tasked with conducting observations of Simon, which observations should have been continuous. Although those observations should have already been conducted with a view to ensuring Simon's welfare, the provision of information at handover about specific health concerns could have alerted Mr Panuccio to the particular need to monitor Simon's physical well-being.

***Failure of CO Panuccio to conduct regular physical observations and dishonesty in CSNSW internal investigation***

*A. Did not conduct regular physical observations of Simon. The physical observations that he conducted were inadequate to ascertain Simon's welfare.*

291. As the Darcy 1 Observation Officer, CO Panuccio was required to conduct checks on the Safe Cell/RIT Inmates on the pod's ground level and record his observations on the relevant ISP/RIT management plan observation record form.

292. The CCTV and the knock-up recordings speak for themselves:

a. At 2:17pm, observation conducted where CO Panuccio stood at cell door – looking in for 4 seconds.

b. From 2:17pm to 7:30pm, there is no time where CO Panuccio stands outside his cell and looks in again.

c. While there were three occasions where he was in the vicinity of the cell, and may have glanced in, they were insufficient for him to make any observations of Simon that would have informed him if he was alive or dead, such as the rise or fall of the chest, other small movements or indications of sleep. CO Panuccio accepted those observations were inadequate. This accords with Director Wilkinson's evidence that checks ought to have involved getting a verbal response from an inmate, or identifying signs of life such as breathing or gross motor movement.

d. At 3:41pm, CO Panuccio realised that Simon's camera was covered and performed a "knock up", requesting that Simon uncover his camera. Despite realising that the camera was covered, and not receiving a response from Simon, no physical health check was conducted.

e. At 5:30pm, Main Control Room called to ask CO Panuccio to ask the inmate in cell 37 to remove whatever was covering his camera. Again, CO Panuccio performed a knock up, and again after receiving no response he failed immediately to conduct a physical check on Simon.

f. CCTV footage does show CO Panuccio briefly walking past cell 37 at about 6:37pm and glancing in the direction of Simon's cell. The capacity for him to make any observations of signs of life would have been limited, a fact confirmed by the fact that the expert evidence is to the effect that Simon must have, by this time, passed away.

*B: The RIT Observation Form completed by CO Panuccio contained false or misleading information, insofar as it represented that electronic observations were being conducted of Simon at 30-minute intervals.*

*C. The statement provided by CO Panuccio on 15 November 2021 contained false or misleading information.*

293. Mr Panuccio accepted in evidence that the RIT Observation Form was not an accurate representation of his observations. By way of explanation, he said that he did not create the documents knowing the contents of it to be false, but rather

thought he would “neat up” the scrappy piece of paper that he was writing on, because he wanted to look “semi-professional.” That “scrappy piece of paper” was produced for the first time in the course of his cross-examination, and it also did not constitute a proper record of his checks.

294. Mr Panuccio said that it never crossed his mind that he was doing anything wrong by creating the RIT Observation Form, the obvious question is why he therefore did it. The forms were not correct, and were created on balance to suggest that these things had been done, after an inmate had passed away. Mr Panuccio had poor record keeping and accuracy in his duty. There was inattention to his work, both in record keeping and in oversight of the inmates. He did not appear to understand the importance of his role.

295. After Simon’s death he was overwhelmed, which is understandable given it was on his watch. He was also likely out-of-his depth in performing the role of Observation Officer. He accepted that in hindsight he could have performed his job to a higher standard.

296. This careless and inattentive attitude was reflected in the comments that he made about the statement he signed on 15 November 2021.

    a. Mr Panuccio said that his statement “just more or less sounded right”, or that it was “semi-okay”, so he agreed to it. He said he didn’t recall reading the paragraph attesting that the statement was true and correct to the best of his knowledge, and signed the statement without being satisfied of the truth of its contents.

    b. His claim that the investigator only gave him five-minutes to read his statement before signing it should not be accepted.

297. The submissions on the part of CO Panuccio were that he had worked for three years for CSNSW, 18 months of which he had spent in escort duties outside of the prisons, and he worked in reception and in general duties across the gaol. He had only worked a few shifts within Darcy.

298. There was no induction process when he moved into Darcy. It was submitted that as there are people on a RIT plan it should be noted that it is surprising that there is no induction when a Correctional Officer starts working in that environment. It was proposed that a useful recommendation would be to

recommend that an induction e introduced for those who come to work in the Darcy unit. Mr Howell drew attention to Dr Sullivan's evidence, and the distinction that Dr Sullivan drew between observations made by a Correctional Officer and observations that could be made within Justice health Staff. Mr Howell likened the experience of a Correctional Officer to that of a lay person, without the training nor experience to make observations that might be described as clinical observation, or draw inferences that might be available to someone with clinical experience. I agree that this was the tenor of both Mr Wilkinson and Senior Correctional Officer Dean. A correctional officer is observing for signs of disorderly behaviour, distressed behaviour or self-harming types of behaviour.

299. CO Panuccio agreed that he could have done his job better. I agree with the submission that the observations he made were inadequate in that they were not sufficient to enable him to assess whether Simon was breathing, and they were not sufficiently frequent.

300. It was submitted that the court should not make a finding that CO Panuccio lied. Indeed, the information he initially provided was not true, and was created for a purpose likely to justify the fact of his inadequate performance in circumstances where a man on his watch had died. The truth was exposed through the watching of the video and other objective evidence. It is said that the objective evidence does not contradict his evidence, however, my interpretation of what I watched was for the most part a lack of interest in Simon, in performing the function of conducting proper and adequate observations and on other occasions casting no more than a cursory glance towards his cell. He often does this at a distance from the cell.

301. In relation to being satisfied of his account that he noticed Simon move his leg at the start of the shift, I find that based on his creation of a record that was not accurate, in what I accept was attempting to satisfy the officer that he had undertaken his role appropriately, I cannot accept him as a reliable witness. His evidence in the witness box was at odds often with what I observed him dong on the CCTV footage. I cannot accept on balance that he made any observation of Simon that he asserts. I find therefore that this piece of evidence that he was able to see Simon's testicle and later could not, does not assist me in relation to the determination of time of death. It was submitted that this was consistent with someone who is not concerned about the wellbeing of about an inmate because

he had earlier witnessed this. However, the remainder of the objective evidence, the fact of the creation of evidence and incorrect statements in the original account given by him would lead me to believe that the disinterest in Simon related more to the fact that Simon was not causing any problems, and as such he was left alone.

302. Mr Panaccio's statements were misleading. These were all matters that were ultimately accepted by Mr Panuccio as being false in his evidence.

303. Mr Panuccio was not a reliable witness. On his evidence I cannot be satisfied that Mr Panuccio saw Simon move his leg when conducting the muster at approximately 2:17pm. Having watched the CCTV it is clear that Simon attracted very little attention while he was lying down. There were a number of very cursory glances his way by Mr Panuccio.

304. Mr Panuccio had no reason to believe that there was anything wrong with Simon. As already discussed, that is the product of a collective or systemic failure, rather than one that can be laid at the feet of Mr Panuccio. In those circumstances, it is unsurprising, albeit still inadequate that that his "observations" were likely directed primarily to observing whether there were any obvious behavioural disturbances such as an inmate self-harming or misbehaving. That was the principal purpose of observations for inmates in assessment cells, although Director Wilkinson confirmed that the observation officer had a wider role of checking on their welfare and wellbeing.

305. There is no evidence that Mr Panuccio showed an intention to be indifferent to Simon's physical ill-health. Instead, he didn't perform his checks thoroughly or attentively, and didn't turn his mind to the possibility that something might have been wrong. Mr Panuccio's inadequate observations did not contribute to Simon's death. On the expert evidence, it is likely that Simon was either deceased, or very close to death, at the time of Mr Panuccio's shift. Both Dr Vickers and Dr Quilty accepted that it would have made no difference to Simon if his state had been observed by Mr Panuccio and an ambulance called. In saying this however, any care or kind treatment of Simon would have perhaps not saved his life, but allowed him to receive at least some medical treatment and not be

left alone to die such a lonely death. It would have afforded his family some comfort that should not be underestimated.

306. Nonetheless, the fact that Simon lay dying and dead on a cell floor, for long enough that he was not found until there were clearly no indications of life, despite supposedly being subject to the highest level of monitoring within the gaol, is both alarming, and carries its own particular trauma for Simons' family.

***Mental Health First Aid Training for CSNSW staff monitoring observation/RIT cells***

307. The officers that were charged with supervising Simon had a lack of awareness of the nature and severity of Simon's mental health issues. The evidence revealed that there is component of the primary training of correctional officers that covers mental health, but it is not as in-depth as the specific course on Mental Health First Aid. Staff may volunteer to participate in that more in-depth training, but it is not mandatory.

308. Director Wilkinson, in response to some questioning, agreed that specific mental health training for the officers supervising Simon would have been of assistance to them. His evidence was that he would love to see all staff within MRRC receive that training, and expressed an intention to liaise with Brush Farm Academy about the availability of training and courses. He expressed no resistance to consideration of that training being mandatory for officers working in Darcy.

309. Given the nature of assessment cells, and the general reasons why someone may be placed on RIT management, there is a heightened need for correctional officers to receive as much assistance as possible in caring for inmates with a mental illness.

310. That is not a barrier to making this recommendation to support the intention expressed by Director Wilkinson in evidence.

311. To this recommendation, I will add further, and that is that all staff at the start of every shift should know the reason why each inmate is in the observation cell. It is unfair to the officers that they are not made aware of this, although I accept this information is available to them currently if it is looked for, however it should form part of the role and should be mandatory information. It informs better treatment

and attention with the knowledge that a person is a mentally ill person, awaiting a hospital bed, who is not able to regulate themselves. The knock up calls reflected at times annoyance, as though Simon could "behave" better, as a person who was able to regulate themselves.

312. This leads to the finding that the last time that Simon was seen alive was at 8.05 am on 19 September 2021.

***Compliance with COPP 1.4 regarding long-term placement in assessment cells***

313. Corrective Services had a policy in place that requires the approval of the Governor of the correctional facility if an inmate's placement in an Assessment Cell exceeded 48 hours. Despite this written policy, Director Wilkinson said that he did not recall any occasions where his approval was sought as required by the policy, including in Simon's case.

314. In Simon's case, had approval been sought as required, Director Wilkinson would have approved his stay in an assessment cell. Given how unwell Simon was, continued monitoring in an assessment cell was undoubtedly warranted, and the appropriateness of his placement was confirmed by the opinion of Dr Sullivan.

315. Although it would not have altered the course of Simon's placement, there are nonetheless issues of transparency and accountability when there is a discrepancy between written policies and practices on the ground. The need to seek approval is also an important safeguard to the use of high-restrictive cell placements.

**CONCLUSION**

316. Simon's death was preventable. This inquest highlights that CSNSW is not and should not be placed in a position to care for a mentally ill person. Once Simon was scheduled arrangements should have been made to provide medical care.

317. This inquest also highlights that the staff of CSNSW, on the other hand, ought to be very aware of why a person has been placed in observation, and it is unfair to that staff not to insist that they have this information as part of their duty. They are entrusted to care, on behalf of the state for these inmates. There is a significant difference between a person who is placed in observation who is at risk of self harm, who is at risk of harm by others, who is having general

behavioural issues, or who suffers from an identified mental illness, or is indeed a mentally ill person awaiting transfer.

318. The recommendations are made to encourage improvements from lessons learned from what can only be described as unacceptable care for Simon. Simon who was a son, a brother, a friend. Simon who struggled with mental illness and was in no state to help himself. Simon who was in both a mental and physical emergency, but nonetheless died unnoticed from a treatable condition, while on a RIT, waiting for transfer to a mental health facility, in a 24 hour surveillance cell.

319. I have determined not to conclude with my words, but the words of Simon's family. They succinctly and eloquently summarise this inquest in family statements:

> "This inquest has been extremely challenging for the entire Cartwright family. No family expects to be involved in a coronial inquest into a death of a loved one so this has been a new experience and a long wait for the answers we have sought for years. Particularly we sought to understand why Simon was in custody and the circumstances of his month long stay at MRRC but mostly importantly how he came to die while being in a highly monitored custody unit.
>
> "We are changed forever by the circumstances surrounding his death. Hearing evidence of Simon's pain and the recordings of just a couple of his unanswered pleas for water and the way he was so roughly treated when finally someone went to check on him. Beyond the lack of health care provided the fact that a staff member unilaterally chose to deny Simon water after multiple pleading requests is appalling and a disregard for his basic human rights. We can only regret the many missed opportunities to save him and the thought of what he would have suffered will haunt us forever. We are completely traumatised by what he went through and we are still unable to reconcile the way Simon was treated, which of course has only fully come to light through the brief of evidence and during this inquest.
>
> The breakdown of the system, the misinformation and the errors of Corrective Services and Justice Health at both the staffing and organisational level is something we find difficult to comprehend. Knowing that if certain people had acted differently or procedures had been followed appropriately Simon may have had a different outcome. We can't change the past but this knowledge is something we must live with for the rest of our lives. More than anything we want to ensure that the failures in our custodial system are addressed to prevent the devastation faced by our family happening to another. Accountability for the failures of the custody system, staff training and procedures will bring some form of justice for Simon, his mum and our family."

## RECOMMENDATIONS

### *To Justice Health and Forensic Mental Health*

1. That Justice Health consider a review of policies or procedures for monitoring the food and/or fluid intake of an inmate, with a view to ensuring that food and/or fluid monitoring is undertaken if recommended by a doctor.

2. That Justice Health consider investigating options for:

    a. employing psychologists to provide therapeutic services to inmates; and

    b. creating systematic support for people with personality disorders in custody.

3. That Justice Health give consideration to recommending a medical transfer of psychiatrically ill patients to external hospitals pursuant to s 24 of the *Crimes (Administration of Sentences) Act 1999* in circumstances where no beds are available for a transfer pursuant to s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.

***To the Commissioner of Corrective Services***

4. That Corrective Services consider the implementation of a formal policy that addresses:

    a. the responsibilities of corrective services officers to ensure access to water;

    b. the circumstances in which water to an inmate's cell can be turned off;

    c. the procedures to be followed if the water to an inmate's cell is to be turned off;

    d. the measures that must be taken to ensure than an inmate has sufficient access to water for drinking and hygiene if their water is turned off; and

    e. requirements for maintaining records in relation to the same.

5. That Corrective Services give consideration to taking steps to ensure adherence with COPP 1.4, subsection 3.4, that requires approval of the governor if an inmate's placement in an Assessment Cell exceeded 48 hours.

6. That Corrective Services give consideration to mandating Mental Health First Aid training for officers who are assigned to supervising inmates in observation cells and/or on RIT management.

7. That Corrective Services give consideration to the development of a system that ensures all of those officers who are assigned to supervising inmates in observations cells and/or RIT management are made aware at the start of each shift of the reason why each inmate has been placed in those cells.

***To both The Commissioner of Corrective Services and Justice Health and Forensic Mental Health.***

8. That Corrective Services consider the production of a memorandum outlining what level of service is provided by Corrective Services Staff of an inmate placed in an observation cell (including the 24-hour surveillance cell), to clearly identify and communicate what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and how regularly it will be staffed and viewed, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for circulation to medical staff to allow development and management of treatment plans.

## FINDINGS PURSUANT TO SECTION 81

### Identity

The person who died was Simon Mark Cartwright.

### Date of death

Simon died on 19 September 2021 sometime between 8.05 am and 7.30 pm.

### Place of death

The location of his death was the Darcy 1 Pod within the Metropolitan Remand and Reception Centre in Silverwater, New South Wales.

### Cause of death

The cause of his death was septicaemia secondary to chronic peptic ulcer disease.

### Manner of death

Simon died as a result of undetected treatable natural causes while involuntarily detained as a mentally ill person within the general prison population while waiting 17 days for a bed in a mental health facility.

**ACKNOWLEDGEMENTS**

a. To all who participated in this inquest, for assisting in the process by giving evidence. To each of the representatives of the interested parties.

b. The family of Simon for their keen involvement and investment in the inquest. My sincere condolences for your loss and grief.

c. To Detective Senior Constable Timothy Joseph Marshall, from Cybercrime, previously from Auburn Police Station, for exceptional work.

d. The team assisting the Coroner, Mr Robinson, Ms Health, Ms Pearson and Mr Tosanovic for the extensive time and effort, presentation, organisation and commitment to this inquest.

I now close this inquest.

Deputy State Coroner Kennedy