CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Terry Grady
Hearing dates:	11 December 2024
Date of findings:	11 December 2024
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death – death in custody
File number:	2019/248597
Representation:	Advocate Assisting – T O'Donnell, Coronial Advocate NSW Commissioner of Corrective Services - S Ye, Solicitor Management and Training Corporation Pty Ltd – K Blackstock, Solicitor Justice Health and Forensic Mental Health Network – K. Guildford
Non publication orders:	Non publication orders were made on 28 October 2024. A copy of the orders can be obtained on application to the Coroners Court Registry.

Findings:	**Identity of deceased**: The deceased person was Terry Grady. **Date of death**: Mr Grady died between the 8th and 9th of August 2019. **Place of death**: He died at Parklea Correctional Facility in NSW. **Manner of death:** His death was intentionally self-inflicted. **Cause of death:** The medical cause of the death was hanging.

Table of Contents

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Terry Grady

Introduction:

1. At the time of his death, Mr Terry Grady was 59 years old and in lawful custody at Parklea Correctional Facility, NSW.

2. On the morning of the 9th of August 2019, Mr Grady was found unconscious in his cell with a ligature around his neck. Emergency services were called and CPR commenced. Unfortunately the attempts to resuscitate Mr Grady were unsuccessful and he was pronounced deceased at 8:17am.

The Inquest:

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

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

5. This inquest took place on Wednesday the 11th of December 2024. A brief of evidence was tendered in the proceedings. The brief included police and witness statements, extensive medical and custodial records, executive statements and a report from independent expert, Dr Tarra Shaw.

6. All of the evidence within the brief of evidence has been taken into account in coming to the findings set out below.

7. During the coronial investigation, sufficient evidence was able to be obtained that addressed the issues and concerns raised in relation to Mr Grady's death. This allowed the scope of the inquest to be narrowed significantly to focus only on the mandatory findings under s81 of the Act, resulting in only some short oral evidence from Detective Senior Constable Lee Ball, and the tendering of the brief of evidence.

The Evidence:

Mr Grady's background:

8. Mr Grady was born on the 23rd of March 1960 and raised by his parents in the St George area of Sydney with his brother and two sisters. He attended school until year 9 before leaving to work as a labourer.

9. Around 1980, Mr Grady was involved in a serious motorbike accident and suffered injuries to his leg and back which caused him ongoing issues throughout his life. He had a son, Aaron, born in 1989, to a previous marriage which ended around 1994.

10. Around 1994, Mr Grady met Mariam Halley when they worked together as truck drivers at a warehouse factory in Taren Point. They commenced a relationship together soon after. Mariam revealed that Terry had issues with alcohol abuse and would drink almost every day which impacted on his behaviour. Mr Grady moved to the Central Coast around 2002 to get away from what he perceived as 'bad influences' in Sydney. He purchased an older mobile home which needed to be renovated and he spent a lot of his time planning, designing and building extensions. Mariam reported that Mr Grady was very happy during this time and was not drinking alcohol very often. Mr Grady built an extension on the home for Mariam to move into, which she did in 2003. Sometime after that, Mr Grady reportedly became bored as there were no further jobs to do on the property, and he commenced drinking again.

11. In 2009, Mr Grady sold his home on the Central Coast and at about the same time, his father passed away unexpectedly. Mr Grady reportedly became deeply

depressed at the loss of his father and began drinking heavily and displaying aggressive behaviour.

12. In 2012, Mr Grady reconnected with his son, Aaron, who visited with his girlfriend. The first visit went well, but on the second occasion, Mr Grady drank too much alcohol and there was a push and shove between Mr Grady and his son, which resulted in Aaron packing his things and leaving. Mr Grady reportedly did not speak to his son again before his death. Mr Grady booked himself into a rehabilitation facility for about a week and stopped drinking for about 4 months after his release, which Mariam says was a good period for him and he was happy and doing well. After this, he began drinking again. He was diagnosed with depression in 2014 and was medicated for this condition.

13. Mr Grady continued to drink heavily and was reportedly aggressive towards Mariam on numerous occasions while intoxicated. This escalated in December 2018 when police were called and an AVO was taken out for Mariam's protection, which included the condition that Mr Grady not approach or be in the company of Mariam within 12 hours of drinking alcohol or taking illicit drugs.

Mr Grady's incarceration:

14. Mr Grady was arrested and charged with domestic violence related offences against Mariam on the 5th of August 2019. He was bail refused and taken into custody by police.

15. Due to his level of intoxication and suffering a minor injury to his elbow during his arrest, Mr Grady received treatment at Wyong Hospital before being transferred to Wyong Court Cells on the 6th of August. He was triaged at Surry Hills Police Cells that evening and Registered Nurse Chai completed obtained a phone order for medications as per Mr Grady's GP instructions based on the labelled medication boxes she was provided. The Nurse was also informed that Mr Grady was prescribed Pristiq for depression and completed an urgent Release of

Information (ROI) request to validate this prescription. Mr Grady was then transferred to Parklea Correctional Centre on the 7th of August 2019.

16. Mr Grady undertook his Justice Health Reception Screening Assessment and declared his history of alcohol abuse, chronic back pain and mental health problems. A Reception Induction was completed with the Corrective Officer noting that Mr Grady appeared fine, did not raise any concerns and did not indicate any thoughts of self-harm or suicide. Mr Grady was placed in Area 3, Cell 23, being a wing primarily used for housing new inmates.

The events leading up to Mr Grady's death:

17. At about 3:40pm on the 8th of August 2019, Mr Grady was provided food and locked into his cell. The last recorded sighting of Mr Grady alive was at about 6:18pm by a nurse who provided Mr Grady his medication. His cellmate was unsure of the last time he saw Mr Grady alive that evening. CSNSW Officers attend the cell door on two occasions throughout the night, but only to check the door is secured.

18. At 7:31am on the 9th of August, Mr Grady's cellmate activated the Emergency Cell Button for Cell 23 and informed them that Mr Grady had hanged himself and was deceased in the cell. CSNSW Officers attended cell 23 and observed Mr Grady to be sitting on the ledge facing the cell door with a bed sheet made into a noose tied around his neck. The noose was fastened to the bar overhanging the cell window. Officers moved Mr Grady to the floor and commenced CPR. St Vincent's Health Services staff arrived a few minutes later and paramedics arrived at 7:50am to continue CPR attempts. CPR ceased at 8:17am and Mr Grady was pronounced deceased.

Investigation following Mr Grady's death:

19. Police attended at about 9am and established a crime scene. Police interviewed relevant staff at the facility and Crime Scene officers attended and processed the scene. Mr Grady's body was then transported to the morgue at Lidcombe.

20. An autopsy was conducted by pathologist Dr Kendall Bailey, who subsequently provided a report and determined the cause of death to be 'hanging'. No suspicious findings were made and the toxicology of Mr Grady's blood came back with only non-toxic levels of metformin, paracetamol and ibuprofen.

21. As the coronial investigation progressed, some issues arose in Mr Grady's care and treatment which warranted further consideration:

The issue of 'hanging points' in cells

22. Consideration was given to the safety of the cell Mr Grady was in and the reduction of hanging points for the safety of prisoners. A statement was provided by Ms Julie Ellis, the Director of the Operational Performance Review Branch, who highlighted the hanging point remediations that had occurred at Parklea Correctional Facility since Mr Grady's death. The area in which Mr Grady was kept now houses only normal placement inmates who are not-at-risk. Vulnerable inmates and new inmates like Mr Grady, would be kept in a newly built area (Area 6) which were constructed pursuant to the Victorian Department of Justice's Cell and Fire Safety Guidelines and are as ligature proof as possible. Priority funding was also allocated to Parklea Correctional Facility for the further remediation of hanging points in other cells.

Delayed provision of prescription medication

23. The coronial investigation uncovered that Mr Grady had not received one of his prescribed anti-depressant medications, Pristiq, since being taken into custody. A release of information request had been completed upon his triage at Surry Hills,

but the relevant information to confirm this prescription was not returned until the day of Mr Grady's death. Mr Grady was assessed by a General Practitioner on the 7th of August 2019, who ordered a new prescription for Ibuprofen and Panadol Osteo to manage Mr Grady's chronic pain, but did not prescribe Pristiq, instead kept the prescription pathway already in place.

24. A report was requested from Dr Tarra Shaw, an independent psychiatrist, to assess the care and treatment provided to Mr Grady and the potential effects of him not being provided with Pristiq for the period of time he was in custody. Dr Shaw describes Pristiq as a useful and reasonably safe medication to prescribe for depression and anxiety but highlighted the risks involved when it is suddenly discontinued. Patients that do so can suffer withdrawal syndrome with side effects presenting themselves fairly quickly.

25. Dr Shaw states that a person such as Mr Grady who was on 100mg a day, would typically start experiencing withdrawal effects within 1-5 days of discontinuation. These side effects can include anxiety, dysmorphic mood, agitation and confusion. Dr Shaw notes that Mr Grady's risk of suicide may have increased if he was withdrawing from Pristiq but highlights that he had a number of risk factors for suicide, including alcohol dependence and chronic pain, hence opining that it was likely a combination of things that increased his risk. As Mr Grady was not a patient under direct clinical care at the time, Dr Shaw cannot say for certain whether Mr Grady was actually suffering withdrawal symptoms from Pristiq or alcohol. She notes that on the 7th of August he was assessed as not being intoxicated or showing any withdrawal symptoms. Dr Shaw was not critical of the delay in obtaining Mr Grady's Pristiq prescription, noting that the two days it took was actually reasonably fast considering the steps that are involved. Dr Shaw stated that ordinarily, in a clinical setting, once clinicians became aware that Mr Grady was prescribed Pristiq, they would chart it for him without waiting on the ROI request, but there may be reasons for this approach to be different in a correctional facility. Dr Shaw also notes that in 2019, not many people had opted into the national database 'My Health Record', which now allows practitioners to see immediately what patients have been prescribed.

26. A supplementary statement was provided by Ms Katya Issa, the Operations Manager for St Vincent's Correctional Health. Ms Issa highlights the changes and improvements that have been implemented since Mr Grady's death. Changes have been made to the substance withdrawal policies, particularly in relation to the alcohol and benzodiazepine withdrawal procedures, with the objective to provide effective and safe treatment for patients undergoing withdrawals. In 2020, St Vincent's Correctional Care introduced the Medication Reconciliation Policy and Procedure, which has made changes and improvements to the medical review for prescription medication. Other changes are highlighted by Ms Issa, including updated staff training, improvements in communication between St Vincent's Correctional health staff and MTC correctional officers, additional staffing and changes to the clinical care structure provided. It has been reported that these changes have produced improved documentation and review systems for health problems, better qualified and equipped nurses and improved emergency response procedures.

27. In light of the changes and improvements adopted since Mr Grady's death, I am satisfied that sufficient and appropriate steps have been taken to reduce the risk of a similar tragedy occurring and I do not propose to make any further recommendations.

28. I would like to offer my sincere condolences to Mariam and Mr Grady's family for the sad loss of Terry.

Findings required by s81(1)

29. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

30. The deceased person was Terry Grady

Date of death

31. Mr Grady died between the 8th and 9th of August 2019.

Place of death

32. He died at Parklea Correctional Facility in NSW.

Cause of death

33. The medical cause of the death was hanging.

Manner of death

34. The death was intentionally self-inflicted.

35. I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner

11 December 2024