



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of RD
Hearing dates:	3 – 5 March 2025
Date of findings:	10 September 2025
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death in Corrective Services NSW custody – whether care and treatment concerns
File number:	2021/00339279
Representation:	<p>Mr M Robinson instructed by A Shrestha of the Crown Solicitors Office appearing as counsel assisting the coroner.</p> <p>Ms D White instructed by J Walshe of the NSW Department of Communities and Justice appearing for the Acting Commissioner of Corrective Services NSW.</p> <p>Ms K Holcombe instructed by K Hinchcliffe of Makinson d'Apice appearing for the Justice Health and Forensic Mental Health Network.</p>
Non-publication order	<p>A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to certain material contained within the brief of evidence. Further non-publication and pseudonym orders have been made pursuant to s75(2)(b) and s75(4) of the <i>Coroners Act 2009</i> (NSW). Copies of these orders are on the Registry file.</p>
Findings:	<p>RD died on 26 November 2021 at the Metropolitan Special Programs Centre within Long Bay Correctional Centre, Malabar, NSW.</p> <p>RD died by hanging, which was intentionally self-inflicted while he was in the lawful custody of Corrective Services New South Wales serving a sentence of imprisonment.</p>

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1 Introduction

- 1.1 RD was in the lawful custody of Corrective Services NSW (**CSNSW**) serving a sentence of imprisonment when he took his own life on 26 November 2021. He was 70 years old at the time of his death.
- 1.2 RD was survived by his wife, JD, and his daughter, HD, both of whom attended the inquest into RD's death. They remembered RD as a man whose life revolved around water and his passion for all types of fishing. He was an enthusiastic recreational fisherman and for many years earned his living as a trawler skipper and owner. In his later life RD became an advocate for those working in the fishing industry, a role in which he achieved some success and of which he was justifiably proud.
- 1.3 RD had considerable practical skills, a 'Mr Fix It' who was able to understand and repair a variety of machines. These skills proved very useful and were highly valued during his time in custody where he was known as both a competent and hard-working inmate mechanic.
- 1.4 Despite the difficulties that RD and his family faced due to the offences RD was charged with and his subsequent incarceration, it was clear that his wife and daughter continued to love and support him. RD was in daily contact with them during his time in gaol.
- 1.5 On behalf of the Coroners Court of NSW I acknowledge the grief felt by RD's friends and family as a result of his death and offer my sincere condolences for their loss.

2 Why was an inquest held?

- 2.1 A coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that the coroner can answer questions that are required to be answered pursuant to section 81 of the *Coroners Act 2009* (**the Act**), namely, the identity of the person who died, when and where they died, and the cause and manner of that person's death.
- 2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their liberty, CSNSW assumes responsibility for their care, 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 CSNSW and the Justice Health and Forensic Mental Health Network (**Justice Health**) cared for a person in custody in a reasonable and appropriate way.

- 2.3 The coronial process represents an intrusion by the State into what is usually one of the most traumatic events in the lives of those who have lost someone close to them. An inquest by its very nature unfortunately compels the family and friends of a deceased person to re-live events often several years after their loved one's death, and to do so in a public forum. I acknowledge that this is an entirely foreign, and sometimes distressing, experience for those who are dealing with the loss of someone they loved.

3 The inquest

- 3.1 An inquest is a public hearing, held as the final part of an investigation into the circumstances of a person's death. In RD's case, it was the culmination of a process that began when his death was first notified to the coroner on 26 November 2021.
- 3.2 Much of the material gathered during the investigation into RD's death was tendered at the commencement of the inquest in the form of a three-volume brief of evidence. There was no factual controversy in relation to the circumstances leading to RD taking his own life. For this reason, many witnesses who provided statements were not required to give evidence. The court did, however, hear evidence from six lay witnesses and three institutional witnesses employed by CSNSW and Justice Health, as well as expert evidence from Forensic Psychiatrist, Dr Richard Furst.
- 3.3 While I am unable to refer specifically to all the documentary and oral evidence in detail in my findings, it has been comprehensively reviewed and assessed.
- 3.4 A list of issues was prepared before the inquest commenced. These issues guided the coronial investigation and shaped the conduct of the inquest. However, an inquest can tend to crystallise the areas which need attention. I intend to deal with the most important issues as they emerged during the proceedings under the broad headings below.

4 RD's mental health history

- 4.1 On 15 December 2016, RD was arrested and charged with historical child sexual offences. He was subsequently released on bail.
- 4.2 RD had begun to struggle with his mental health after the allegations first became known to him. The difficulties he was experiencing increased after he was charged. Because of this, in December 2016, RD's General Practitioner (**GP**) started him on anti-depressant medication, Sertraline.
- 4.3 On 17 January 2017, RD attempted suicide by hanging. This appears to have been a spontaneous act, with limited pre-planning. He was found by his wife, JD, some hours after the attempt as he sat dazed on the floor. JD took RD to Batemans Bay Hospital. He accepted his need for treatment and so was not involuntarily detained. He was later transferred to the Intensive Care Unit at The Canberra Hospital (**TCH**), where he remained for treatment of the physical sequelae of the attempted hanging.
- 4.4 The trigger for RD's suicide attempt was recorded as 'extreme stress' caused by the criminal charges, which had been preceded by an extended period of chronic stress over a period of twelve months. The impression of RD's treating team was that he had suffered a 'situational crisis' and 'psychosocial stress' which culminated in the attempted suicide.
- 4.5 RD was discharged from TCH on 1 February 2017 and was transferred to the Hyson Green Unit at Calvary Bruce Private Hospital in the ACT for treatment of his mental health. He was admitted under the care of psychiatrist, Dr Murali Reddy (**Dr Reddy**). During his admission to the Hyson Green Unit, RD received individual and group psychotherapy, along with antidepressant medication. His diagnosis was adjustment disorder with symptoms of depression and anxiety.
- 4.6 RD was discharged on 17 February 2017 with follow-up by his GP and psychiatrist, Dr Reddy. He was prescribed 150 mg of antidepressant medication daily. RD was also referred to the Specialist Mental Health Service for Older Persons. He attended weekly appointments for the first six weeks and then monthly reviews for a further three months with psychogeriatrician, Dr Beverley Rayers. RD was discharged from Dr Rayers' care in June 2017, with the discharge summary recording that RD reported nil depressive symptoms, stable mood, found enjoyment in activities like fishing, and

had no suicidal ideation. He expressed an intention to continue treatment with Dr Reddy.

- 4.7 Dr Reddy subsequently reported that RD showed improvement and stability in his mental state with significant improvement in his psycho-social functioning. That improvement in turn led to a decrease in his antidepressant medication from 150 mg to 50 mg daily. A medical record of 2 April 2019 records that when RD's GP, Dr Kallinen, reduced RD's medication to 25mg daily, RD had a relapse of depressive symptoms with ruminative thinking, and his Sertraline was duly returned to a dose of 50mg daily. That resulted in cessation of his ruminative thinking, and an improvement in his mental state and psychosocial functioning.
- 4.8 RD saw Dr Reddy in December 2018, April 2019 and again in August 2019. Between May and November 2019, RD appeared to manage well in the community with no apparent decline in his functioning. The evidence is that RD remained on Sertraline 50mg once daily, until he decided to self-cease taking the medication, a decision he communicated to his GP. RD reported that notwithstanding discontinuing the medication, his mood was holding up well, and he was employing 'psychological measures' instead.

5 RD's mental health on his entry into custody: December 2019

- 5.1 In November 2019, nearly three years after he was charged, RD faced trial at Wollongong District Court. On 4 December he was found guilty of four out of five charges and remanded into custody at Amber Laurel Correctional Centre (**Amber Laurel**).
- 5.2 Inmates received into custody are required to be screened in accordance with CSNSW *Procedures for the Reception, Screening, Induction and Orientation of CSNSW Inmates*. The policy requires that each newly received inmate must undergo a Reception Screening Assessment (**RSA**) by a Justice Health nurse to identify any physical health, mental health, and alcohol and drug needs, and any necessary treatments. The policy also requires that a screening interview must be conducted by a CSNSW Support and Programs Officer (**SAPO**) within 36 hours of an inmate's reception into the correctional centre or on the first working day. The assessment tool

used by CSNSW to screen inmates as of November 2019 was the Intake Screening Questionnaire (**ISQ**).

- 5.3 On 5 December 2019 Amber Laurel made a Release of Information (**ROI**) request to the medical practice RD had been attending, Curalo Medical Clinic, for ‘current medication, current medical issues, treatment + regimes.’ The following day, Curalo Medical Clinic produced a one page ‘Medication Summary’. It recorded RD’s medications as Crestor 10 mg daily for hypercholesterolemia (last prescribed 08/05/19) and Pariet EC 20 mg daily as directed for gastro-oesophageal reflux (**GORD**) (last prescribed 10/07/18). This document did not identify medical conditions other than by reference to indications for medication and was silent with respect to RD’s depression and previous suicide attempt.
- 5.4 On 7 December 2019, RD was transferred from Amber Laurel to the Metropolitan Remand and Reception Centre (**MRRC**). On his receipt into MRRC, CSNSW officers completed an ISQ. The ISQ records that ‘in 2017 inmate tried to hang himself, that RD suffered from depression, and that he was ‘currently unmedicated.’
- 5.5 On 8 December 2019, Justice Health registered nurse (**RN**) Kylie Chapman completed a RSA. In the RSA, RD is recorded as reporting that he had been treated for depression by his GP, that he had tried to end his life by hanging in January 2017 due to depression, and that he was hospitalised as a result and medicated for some time. RN Chapman also records that RD ‘feels fine’ and ‘is adamant he has no current TOSH¹, guarantees safety.’ RN Chapman placed RD on the primary care waitlist and the mental health nurse waitlist.
- 5.6 RN Chapman also made a ROI request to RD’s GP, Dr Kallinen, at Curalo Medical Clinic, for ‘medical history + medications’ for ‘last 12 months.’ This ROI was never despatched, seemingly because the earlier ROI from Amber Laurel to Curalo Medical Clinic had already been responded to.
- 5.7 On 9 December 2019 RD was triaged for access to psychological services. He was placed on the waiting list for ‘Psych 2 Sub-Acute Mental Health Impairments on the basis of information available, to be seen in order of priority.’

¹ thoughts of self-harm

5.8 In her evidence, CSNSW Principal Psychologist, Bianca Spaccavento, explained that CSNSW psychologists work to a triage system. 'Psych 1' is a priority service requiring that an inmate be seen within 3 days, and is applied where there is acute suicidal or self-harm risk, acute need for mental health assessment, or an acute risk of violence towards others within the correctional centre. If the need is ascertained as being less than acute in any of those areas or related to another area, generally the person will be triaged as 'Psych 2', requiring them to be seen within 12 weeks. Ms Spaccavento's understanding was that about 95% of Psych 2 inmates were seen within the 12-week timeframe.

The adequacy of the material provided in response to the ROI

5.9 Forensic Psychiatrist, Dr Furst, was of the view that at the time of completing the RSA, and subsequently, Justice Health should have obtained more material than the single page document produced by Curalo Medical Clinic, for example, further material from Curalo Medical Clinic, or records from RD's other current treatment providers, including his psychiatrist, Dr Reddy.

5.10 The failure to obtain information in addition to the single page from Curalo Medical Clinic does not appear to have resulted in a failure of policy in respect of RSAs and ROIs, which anticipates that it may be necessary to request material from specialists. What occurred appears to have been an omission, in RD's circumstances, to identify the inadequacies in the material produced by Curalo Medical Clinic, and thereafter to seek further relevant material.

5.11 Notwithstanding that inadequate information was obtained from RD's treating practitioners on his entry into custody, Dr Furst considered that RD was provided with an appropriate and adequate level of care and supervision by Justice Health, and in circumstances where RD had provided a relatively thorough self-report, Justice Health was in a position to adequately assess his risk of self-harm and suicide on his entry into custody. I accept that although the extent of the material obtained by Justice Health was deficient, RD was forthcoming with his mental health history including his previous suicide attempt, his diagnosis of depression and the fact that he had been prescribed anti-depressants. Accordingly, the deficiency in the available material did not adversely affect the care RD received from CSNSW and Justice Health during the period immediately following his admission into custody.

5.12 According to psychiatrist, Dr Matthew Hearps, who is Justice Health's Clinical Director of Custodial Mental Health, since RD's death, changes have been made to clarify that an ROI is to be sent out for all significant health encounters disclosed by an inmate, including previous suicide attempts which warranted hospital care. As of June 2023, Justice Health NSW Policy 1.225 *Health Assessments in Male and Female Adult Correctional Centre and Police Cells* provides that when a health condition is identified during an RSA:

- (a) an ROI request must be sought from the patient's regular health service provider through the Justice Health NSW Health Information and Records Service (**HIRS**) within 72 hours of a completed RSA;
- (b) once the ROI documentation is received, HIRS scans the ROI into the Justice Health electronic health system (**JHeHS**), which must be reviewed/signed through the JHeHS Scanned Document Dashboard;
- (c) the clinic must review the documents produced by the patient's community treatment provider(s) through an eProgress note and link the records to that eProgress note; and
- (d) JHeHS must be updated accordingly in regard to health condition information.

The failure to record an 'alert'

5.13 At no time during the completion of the intake process did either Justice Health or CSNSW register on RD's file an 'alert' in connection with his previous suicide attempt. The evidence suggests that this was because at the time neither organisation recorded an alert for an attempted suicide if the suicide attempt did not occur whilst the individual was in custody. The evidence of Justice Health's executive witness, Dr Hearps, is that since 4 July 2022, any known attempt at suicide, irrespective of whether it occurred in custody, results in the placement of a 'suicide attempt' alert on the Justice Health's Patient Administration System. The evidence was that CSNSW had not changed its policy and will not place a similar alert on their system unless it occurred while in custody. Adam Riddell, CSNSW Manager of Security, Statewide Operations, Security and Custody, expressed concern about the extent to which a 'suicide attempt' alert would affect the circumstances of an

inmate's custody arrangements with the result of unduly restricting an individual's opportunities within the custodial environment and potentially rendering their experiencing of custody more onerous.

- 5.14 There is no suggestion that had an alert relating to RD's 2017 suicide attempt been placed on the CSNSW or Justice Health information systems, that RD would have been managed more assertively or that this death may somehow have been avoided. The evidence suggests that in fact, such an alert may have had the effect of curtailing his opportunities while in custody, particularly the opportunity to engage in employment, something that Dr Furst felt was generally protective in terms of the mental health of inmates.

6 RD's mental health after sentence: February–July 2020

- 6.1 On 8 February 2020, RD was transferred from MRRCC to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex (**Long Bay**).
- 6.2 On 14 February 2020 RD was sentenced to a custodial sentence of four years, commencing 4 December 2019 and concluding 3 December 2023, with a non-parole period of two years, expiring 3 December 2021.
- 6.3 Material from RD's GP, Dr Kallinen, and from his psychiatrist, Dr Reddy, as well as a report by Forensic Psychiatrist, Dr Andrew Ellis, was tendered on RD's behalf at sentence. As part of his remarks on sentence, His Honour Judge Haesler SC, referred to that part of Dr Ellis' report that stated that RD 'should be monitored for suicidal ideation while in custody.'
- 6.4 There is no evidence that CSNSW received any of the material tendered on RD's sentence. The evidence of CSNSW Principal Psychologist, Ms Spaccavento, was that such material is not 'stored in [RD]'s CSNSW Psychology file and a search of his general case management file did not indicate the presence of such documents either.' Her evidence was that such material is generally only provided 'if a decision had been made by a court to send the material to CSNSW,' that such material was received 'sporadically,' and that it is generally not sent directly to CSNSW Psychology. Ms Spaccavento advised, however, that if required, CSNSW psychologists could request Community Corrections or Sentence Administration to obtain court documents if they knew of their existence.

- 6.5 On 14 February 2020, apparently due to having received his sentence, RD was reviewed by RN Eloise McFee. The relevant progress notes record that RD was ‘happy with outcome. Good support networks. Denied need for mental health intervention – aware to self-refer if he changes his mind.’
- 6.6 On 16 February 2020, RD completed a Justice Health ‘Patient Self-Referral’ form, in which he requested he speak to a nurse in relation to, among other issues ‘some form of sleeping tablets short term, not sleeping well after sentencing.’
- 6.7 On 18 February 2020, RD was reviewed by nurse practitioner, Linda Malusa. She noted RD was generally physically well, and in respect of mood, she recorded ‘more relieved since sentencing.’ The note further records that RD’s mood was low prior to court and that he had requested to see mental health but ‘feels this is no longer required.’
- 6.8 It appears that RD remained on the waitlist for a psychologist, notwithstanding having expressed that this was no longer required. On 28 February 2020, RD met with CSNSW psychologist, Clare Fookes. The purpose for referral was due to ‘coping issues.’ As part of this review, RD indicated that his mood was a seven or eight out of ten and he denied thoughts of self-harm. He was, at the time, reported to be coping. In her notes of the consultation, Ms Fookes recorded that RD reported he had ‘settled down’ after sentencing and that he denied thoughts of suicide or self-harm. She recorded that RD’s 2017 suicide attempt was ‘in the context of the initial charges for his court case.’ Ms Fookes considered that RD was a ‘low intermediate risk of suicide, self-harm, or harm to others’ and she concluded that no follow up was required. She records ‘Inmate was encouraged to re-refer back to psychology by speaking to a Corrective Services Officer and filling out a referral form if he has any other concerns.’
- 6.9 During her oral evidence, in response to questions about the possibility of inmate’s having regular consultations with a psychologist, Ms Fookes explained that although fortnightly or monthly consultations were possible, the nature of demand for psychological services at Long Bay compared to the number of staff in the psychology team, was such that ‘[i]t’s not really how the system works.’ Although Ms Fookes had not had access to material tendered on sentence on 14 February 2020, nor the sentencing remarks made by His Honour Judge Haesler SC, she felt that this would

be 'too much material to get through' and that it 'wouldn't be of a high priority.' Despite not having seen this material, she was aware of RD's previous suicide attempt and the context in which it was made.

- 6.10 On 24 March 2020, RD was reviewed by a RN upon his transfer into a different section of MSPC. He was noted to be 'on meds', 'stable, nil suicidal ideation. Guarantees own safety. Normal cell placement.'
- 6.11 On 12 May 2020, RD underwent mental health review by Adam Takacs, clinical nurse specialist (**CNS**). By reference to the note in the JHeHS records, it appears that this review occurred in response to RD reporting difficulty sleeping in February 2020 and requesting sleeping pills. CNS Takacs' notes record 'history of depression, attempted hanging 2017, denies TOSH guarantees safety at this time.' CNS Takacs obtained a detailed history, including that RD was diagnosed with depression by his general practitioner in 2016, and was on anti-depressants for two years. RD could not recall the name of the antidepressant he was on, volunteering that it was something that sounded like 'seretin,' from which CNS Takacs correctly concluded that RD had been on Sertraline. RD reportedly stated that he felt well and did not consider he needed to go back on Sertraline. He reported that his appetite had improved, describing it as 'too good,' was attending to daily self-care, was socially active and maintaining regular contact with his wife, daughter and friends. It was recorded that he 'makes phone calls, gets visits, writes letters.' He reported that he was well supported. RD further reported that he had adapted to prison and was coping well, that he was getting on with his cell mate and generally felt motivated. Mental state examination was normal, and CNS Takacs considered that there was 'nil indication for psychiatrist/GP or ongoing MH clinical nurse specialist review.' The note indicates that RD was informed he could self-refer if needed.
- 6.12 RD had bloods taken on 24 April 2020, and the results were followed up on 29 May, 4 June and 24 July 2020. There is no record that on any occasion that RD saw the doctor, that he reported any issues in relation to his mental health.
- 6.13 On 3 July 2020, RD attended the clinic at MSPC and was reviewed by a RN. He was complaining of right sided rib cage pain, ongoing for a period of 10 days. The physical examination was normal; he was provided with a course of paracetamol and was

advised to inform the medical clinic if his condition deteriorated. There is no reference in the medical documents to RD having raised any concerns after this.

- 6.14 Although it appears that RD may have initially experienced some difficulties with his sleep after receiving his sentence, these issues appear to have settled reasonably quickly. Notwithstanding this, he was still assessed by a CSNSW psychologist two weeks after he was sentenced and reported that he was coping well, such that no further follow up was required. I am satisfied that there are no shortcomings in the care that RD received from CSNSW and Justice Health between February and July 2020.

7 Further allegations: 7 July 2020

- 7.1 On 7 July 2020, JD contacted Long Bay Correctional Centre. She spoke with SAPO, Francesca Murden. JD indicated to Ms Murden that she would be advising RD that afternoon that further allegations of sexual offending had been made against him. In a contemporaneous note made by Ms Murden, she recorded that JD did not think RD would receive the news well and that his mental health may be adversely affected. JD asked that officers 'keep an eye' on RD.
- 7.2 In response to the concerns raised by JD, Ms Murden emailed MSPC Senior Assistant Superintendent, Shane Hopkins. Ms Murden copied her direct supervisor, Senior SAPO Kristy Ohlsen, into the email. She advised:

I have just received a call from [JD] the above inmate's wife ... informing that she will be talking to the inmate this afternoon to let him know that more allegations have been made against him.

[JD] thinks he won't be taking the news well and she's concerned that this may affect him adversely, she asked that an eye be kept on him.

A SAPO will follow up with him tomorrow if the need arises.

Mr Hopkins responded, *Okay, thanks for letting me know Francesca.*

- 7.3 Ms Murden's evidence was that following this reply, she was confident that the matter was being followed up and that any appropriate action with regards to RD's safety would be managed by custodial staff. In the days following this email exchange, Ms Murden's evidence was that she did not receive instructions from the

Senior SAPO to attend a 'Crisis Intervention' and there were no requests for a Support Service intervention from custodial staff (these are administrative processes to request a SAPO to attend to an inmate) with regards to a follow up appointment with RD. Her evidence was that these were the usual requests she would have expected to have received if further action was required beyond her routine duties. In their absence she did not take any further steps as she believed her email satisfactorily brought attention to the concerns raised by JD.

- 7.4 Mr Hopkins' evidence was that due to Ms Murden stating that RD would be seen the next day if needed, he decided to wait for the results of any further interaction. As a result of Ms Murden's email alone he did not consider further action was required. His view was that while the information provided by JD and reflected in the email from Ms Murden was informative, ultimately it outlined an anticipated concern for an inmate by their loved one, information that, in his experience, officers receive on a regular basis given the very nature of custodial settings. Mr Hopkins asserted that, had he been aware of RD's previous suicide attempt, he would have ensured that RD was followed up the next day by a correctional officer. He did not consider it was appropriate to take a reactive approach, and wait and see, for example, whether RD received the news poorly, considering that previous suicide attempt. He agreed that there were a range of options which could have been taken, including review by a correctional officer, review by a SAPO, or referral to CSNSW Psychology.
- 7.5 It appears that neither Mr Hopkins nor Mr Murden considered that they were responsible for proactively following up the concerns raised by JD and ultimately no further action was taken. Dr Furst considered that the absence of any response was inadequate given the concerns raised by JD.
- 7.6 On the evidence of CSNSW Manager of Security, Adam Riddell, it fell to the discretion of the custodial officer as to what action should be taken in relation to the concerns expressed by JD. However, the evidence is not that JD expressed a concern that RD would seek to end his life, that he had made any relevant threat, or that this was for some other reason a crisis. She requested simply that an eye be kept on RD. Although there was no elevated or heightened level of supervision, CSNSW policy at the time did not require a different approach. In any event, RD appears to have coped with the July 2020 news of further allegations. His CSNSW notes do not record any changes in

his behaviour, and although before 7 July 2020 JD had self-referred to Justice Health, he did not do so on this occasion.

- 7.7 Since RD's death there has been an update to Custodial Operations Policy and Procedure (**COPP**) 6.3 *Inmate Health Needs*. The update provides that when a correctional officer receives information regarding an inmate's health from a family member, it is classified into two categories. Category 1 information relates to the provision of significant information requiring immediate action, for example, risk to self, thoughts of self-harm or suicide, or thoughts of harm to others. Category 2 concerns the provision of general health information, such as concern about access to medication or other health related information. The updated COPP provides that in the event of a category 1 notification, staff must convey the concerns to a Functional Manager/Officer in Charge and to Justice Health, inform the family member or friend that this will occur, and provide a case note detailing these interactions. In the event of a category 2 notification, staff must ask the family member or friend to contact Justice Health directly, provide relevant contact numbers, and case note the interaction.
- 7.8 Had the policy been operative at the time of JD's contact with Ms Murden it appears that it would have required a category 2 response. The fact that CSNSW has amended its policy in the way outlined means that there is no need for any recommendation arising from this incident.

8 RD's further mental health treatment: July 2020– November 2021

- 8.1 Between July 2020 and November 2021, RD managed well in custody. He had occasional engagement with Justice Health and appears not to have been seen by a CSNSW Psychologist during the period. The evidence suggests that was reasonable as RD appeared to be coping well in custody.
- 8.2 The CSNSW records of 10 September 2020 record '[RD] reports he is currently not medicated for his mental health and his wellbeing has improved. In the community he did receive support for depression.'
- 8.3 After September 2020, RD's interactions with Justice Health were limited. He made only one self-referral for treatment in February 2021, which concerned his eyesight,

and was not seen by a CSNSW psychologist. Dr Furst's review of RD's Justice Health and CSNSW records suggest that he was managing well during that period, and that there was no basis for criticism of the absence of review.

- 8.4 On 17 July 2021, RD was reviewed by a RN for the purpose of updating his Health Problem Notification Form (**HPNF**). He denied medical and mental health issues and denied thoughts of harm to himself or others. He provided guarantees in respect of his safety, and an updated HPNF was prepared.
- 8.5 On 22 July 2021, RD was reviewed by Senior Community Corrections Officer, Laura Unicomb, as part of the process leading up to his anticipated release to parole in December 2021. By reference to the notes of the interview, and Ms Unicomb's statement, it is apparent that RD advised that he had experienced some mental health issues prior to being charged and that he had been on medication for stress. He further noted the suicide attempt when he was first charged and advised that his psychiatrist noted that it was likely due to stress. RD noted that he had been seeing Dr Reddy in Canberra and expressed that he would like to re-engage with him upon his release. Given the nature of RD's offending, Ms Unicomb advised him that he was not going to be permitted to return to reside at his home whilst on parole, due to its proximity to the victims of his offending. Evidently, it became difficult for RD to identify suitable alternative accommodation, and Ms Unicomb advised that he could choose to remain in custody, serve his remaining sentence, and then return to the family home. RD is recorded as stating that spending another two years in custody 'would kill him.' Ms Unicomb said that RD engaged well with the balance of the interview and no concerns were noted.
- 8.6 Although Ms Unicomb recorded these matters in the CSNSW information system, she did not take any action. She did not interpret RD's statement that a further two years in custody 'would kill him' as a threat and did not perceive there to be any realistic prospect that he would not be released to parole, particularly as she knew that a lack of appropriate housing was generally not a basis upon which parole was refused.
- 8.7 Ms Unicomb was aware of RD's prior suicide attempt, and of Dr Ellis' opinion that RD needed to be monitored for suicidal ideation, indeed, she was perhaps the only person who had read a copy of Dr Ellis' report. In her oral evidence, she reported that she would have been concerned for RD's wellbeing had she thought there was a

realistic prospect that he would not be released to parole, but she had every expectation that he would be. Her evidence was that at no time prior to RD's death was she notified of the further charges, that he was bailed refused, or that, accordingly, he was not going to be released to parole. In the circumstances in which they were made, RD's comments to Ms Unicomb did not require any further action by her or anyone else.

8.8 Ms Unicomb's case notes of 31 October 2021 record that RD was looking forward to parole in four weeks and had regular contact with his wife and daughter regarding a new residence to comply with his parole conditions.

8.9 RD received his parole notification on 17 November 2021. However, on 22 November 2021, a few days before he was due to be released to parole, he was charged with further sexual offences and was refused bail.

9 Events preceding RD's death on 26 November 2021

9.1 From March 2020 until his death on 26 November 2021, RD was employed at MSPC five days a week as a laundry mechanic. He was one of about twenty inmates who worked in the laundry. RD's work was overseen by CSNSW Senior Overseer, Harpreet Singh Bhatti. As part of his duties, RD was responsible for tending to the boiler and letting off the steam. Because he was a trusted inmate who worked as a laundry mechanic, he was able to move relatively freely in the laundry room and the boiler room contained within the laundry. He was also able to access tools, although these were accounted for at the end of each shift.

9.2 Each day, inmates were mustered in the accommodation area at 7:00 am after which laundry staff were brought to the laundry, where there was a further muster at about 7:30 am. On 23 November 2021 at about 7:51am, RD was captured on CCTV in the laundry workshop. He is seen selecting a long black rope and a wire cable. He then returns the rope to the wall and leaves the wire on the table. While it may not have been apparent at the time, with the benefit of hindsight, he was clearly fashioning a noose.

9.3 On 24 November 2021 at about 7:31am RD left the boiler room and entered the laundry workshop. He used a measuring tape to measure the length of the wire cable.

A few minutes later he walked towards the boiler room while holding the wire cable, then a short time later, he left the room without the cable.

9.4 On 26 November 2021 at about 7:25 am RD walked towards the boiler room, after which he is not again captured on CCTV footage. At some time between 7:25 am and 9:02 am RD rigged up the wire cable to a beam in the boiler room and hanged himself.

9.5 At 9:00 am on 26 November 2021, Senior Overseer Harry Bhatti noticed that RD was missing and went to look for him with Overseer Sompala Rubasinghe. The officers went to the boiler room where they noticed that the roller shutter was down. They were unable to open the roller shutter since the controls for the room were located on the inside. The officers called out RD's name to check if he was there and did not hear a response. They looked through the perforation in the roller shutter and saw a pair of legs suspended in the air. Mr Bhatti immediately called for medical assistance and incident response on the radio. When the responding officers arrived at the scene, they broke down the roller shutter and gained entry. RD was placed on the ground, and CPR was provided until the arrival of paramedics who, after assessment, declared him to be deceased.

9.6 A postmortem examination conducted on 30 November 2021 showed extensive acute haemorrhage within the soft tissues of the anterior and posterior of RD's neck, most marked on the left, where there was a full thickness defect in the common carotid artery and an intimal tear (partial thickness tear in the inner layer of the vessel) within the internal jugular vein at the same level. Palpable fracture fragments were noted at the region of the second cervical vertebra. The forensic pathologist recommended that RD's cause of death be recorded as 'hanging.'

9.7 As a direct result of RD's death, several changes have been made to the laundry operations:

(a) where there had previously been only one overseer, there is now a second overseer allocated to the laundry to assist with supervision;

(b) a reduced number of tools are available for use by inmates working in the laundry and accessing the workshop;

(c) Instead of three musters a day, there are now five, providing a greater number of opportunities to identify and account for inmates;

(d) changes have been made to the boiler room to facilitate air flow so that the boiler room can remain locked without the heat damaging the equipment; and

(e) the controls for the roller door have been moved to the outside of the door.

9.8 There is no evidence that after he was refused bail, that RD disclosed to staff or inmates his thoughts in relation to the fresh charges, or his intention to take his own life. There is similarly no evidence that he made any request for access to mental health services.

9.9 In his evidence, Mr Riddell spoke of individuals returning from AVL being asked a question about their welfare, something that appears to have occurred when RD returned from his AVL appearance on 14 February 2020 having received his sentence. When RD was charged with further offences, he was sent to MRRC. That took place by way of a transfer under section 25 of the *Crimes (Administration of Sentences) Act 1999*. Mr Riddell gave evidence that consideration is being given to conducting a welfare check on inmates returning from leave pursuant to s 25, a process that is not currently in place, as distinct from the welfare checks that are conducted on return from AVL. This appears to be a positive measure.

10 Conclusion

10.1 RD's death raises the importance of considering interventions for individuals such as RD who experience an adverse change in the circumstances of their imprisonment. The evidence was to the effect that further charges, an extended sentence, or a refusal of parole, was a stressor for all inmates, irrespective of whether they had RD's history, that is, one where he had previously attempted suicide in the context of the initial charges.

10.2 It is accepted that there are significant challenges associated with managing mental health risks within a custodial environment, particularly in ensuring continuity of care and responding effectively to concerns raised by family members. In RD's case, the evidence suggested some missed opportunities for intervention, communication gaps, and systemic limitations in identifying and addressing heightened psychological distress. However, I do not suggest that had these shortcomings not existed, that RD's death could have been avoided.

- 10.3 For the most part, RD appears to have coped well in custody, and in the brief periods when, for example, he found sleep difficult, he sought, and was provided with, appropriate psychological support. Ultimately the greatest challenge to RD's mental health arose from the additional charges that were laid on 22 November 2021, just days before he was to be released to parole, and the subsequent refusal of bail. It would have been clear to him that irrespective of his plea to the fresh charges, he would have faced significantly more time in custody before they could be finalised. RD began preparing to take his own life the day after he was refused bail. It is difficult to know whether, even if he had been questioned about his mental state following his return to Long Bay from MRRC, he would have disclosed his intention to take his own life. There is no evidence to suggest that there was any failure on the part of CSNSW or Justice Health staff that contributed in any way to RD's death.
- 10.4 Except for the changes made to the operation of the laundry at Long Bay, there have not been any changes to CSNSW or Justice Health policy and procedure that have been implemented directly in response to RD's death. Nevertheless, over time changes have been implemented which touch on issues raised by RD's case.
- 10.5 In RD's case, an inquest was mandatory because he died while in the lawful custody of CSNSW. I am satisfied that while in custody, RD was provided with appropriate care to address and treat his medical and mental health conditions.
- 10.6 Nothing in the evidence in this matter lends itself to the making of recommendations pursuant to s 82 of the Act.

11 Findings

- 11.1 Before turning to the findings that I am required to make, I would like to acknowledge and express my gratitude to Counsel Assisting the Coroner, Matthew Robinson, and to his instructing solicitors, Agrima Shrestha and Alana Galasso of the Crown Solicitors Office, for all the work they have done in investigating this matter and preparing it for inquest.
- 11.2 I also thank Detective Senior Constable Nicholas Middleton for his role in the police investigation and for compiling the initial brief of evidence.
- 11.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was RD.

Date of death

RD died on 26 November 2021.

Place of death

RD died at the Metropolitan Special Programs Centre within Long Bay Correctional Centre, Malabar, NSW.

Cause of death

RD died by hanging.

Manner of death

RD's death was intentionally self-inflicted while he was in the lawful custody of Corrective Services New South Wales serving a sentence of imprisonment.

11.4 On behalf of the Coroner's Court of New South Wales I once again offer my sincere and respectful condolences to RD's family and loved ones for their loss.

11.5 I close this inquest.



Magistrate Kasey Pearce

Deputy State Coroner

10 September 2025

Coroners Court of New South Wales