CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of AP
Hearing dates:	5 – 20 May 2025
Date of findings:	13 May 2026
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – mandatory inquest – homicide – housing of acutely mentally ill inmates
File number:	2018/0046266
Representation:	D Ward SC and A Payten, Counsel Assisting the Coroner, instructed by E Burston of the Crown Solicitor's Office J Harris, instructed by C Dunn and M Katawazi of the Department of Communities and Justice, Legal, representing the NSW Commissioner for Corrective Services B Bradley, instructed by B Ferguson of Hicksons Lawyers, representing the Justice Health and Forensic Mental Health Network
Non-publication order:	Non-publication orders have been made pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW). Copies of these orders are on the Registry file.

Findings:	**Identity** The person who died was AP **Date** AP died on 9 February 2018. **Place** AP died at Westmead Hospital, Westmead NSW 2145 **Cause of death** AP died of the combined effects of neck compression and blunt chest trauma. **Manner of death** AP died as a result of an assault inflicted upon him by a known person while he was in the lawful custody of Corrective Services NSW and housed at the Metropolitan Remand and Reception Centre at Silverwater.

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1. Introduction

1.1 AP, known to his family as Alfie, died in Westmead Hospital on 9 February 2018. At the time of his death, Alfie was an inmate at the Metropolitan Reception and Remand Centre (**MRRC**). He had entered the MRRC on 2 January 2018 after he was arrested, charged with criminal offences, and refused bail. Alfie had only one previous matter on his criminal history, in relation to which no conviction had been recorded. This was his first time in custody. He was 54 years old.

1.2 Mervyn Davidson had a very lengthy forensic history. He was 44 years old in February 2018 and had spent most of his adult life in custody. He was an unwell and very violent person. He had been remanded at the MRRC since 30 January 2017, after he was arrested the previous day for an extremely brutal and unprovoked assault on a cashier at an Aldi Store in Albion Park. He had also seriously assaulted his cellmate at the MRRC on 1 February 2017.

1.3 On the afternoon of 9 February 2018 Alfie was attacked in his cell by Mervyn Davidson, who occupied the adjoining cell. Despite medical intervention to try to save him. Alfie later died in Westmead Hospital due to the injuries inflicted upon him by Mr Davidson.

1.4 The inquest into Alfie's death took place in conjunction with inquests into the deaths of three other inmates, who also died while in the custody of Corrective Services NSW (**CSNSW**) between 2018 and 2020: Ryan Fennell, Ho Pan Chan, and PA. These four matters were heard together because together they highlight systemic issues related to the management of inmates, particularly those with serious mental health issues, by CSNSW and by the Justice Health and Forensic Mental Health Network (**Justice Health**). These findings should be read in conjunction with the findings into the deaths of each of these inmates individually, as well as the findings examining systemic issues arising from the four deaths.

1.5 By the time these proceedings were heard, many years had passed since Alfie's death. This delay was due in part to the need to await the conclusion of criminal proceedings, followed by the delay brought about through the impact of COVID on court proceedings, just after the Supreme Court proceedings ended. Further delay arose because Alfie's death was investigated as part of the wider group of matters that the Court has considered.

1.6 I acknowledge the tragic circumstances of Alfie's death and the devastating impact on his family of losing him. On behalf of the Coroners Court of NSW, I extend my deepest sympathies to Alfie's friends and family for their loss.

2. Why was an inquest held?

2.1 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 by section 81 of 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 A secondary function of a coroner is to consider whether anything that was or was not done in each case might have contributed to the circumstances of the death, and importantly, whether any lessons can be learned that may assist in preventing similar deaths in the future. To this end, pursuant to section 82 of the Act, a coroner can make recommendations arising from the evidence, in relation to any matter connected with the death.

2.3 The combined effect of sections 23(1)(d)(ii) and 27(1)(b) of the Act is that it is mandatory for a senior coroner to hold an inquest in circumstances where, as in this case, a person has died while an inmate of, or temporarily absent from, a *correctional centre*, as it is defined in the *Crimes (Administration of Sentences) Act 1999*. The MRRC falls within the relevant definition of a *correctional centre*. Although Alfie died at Westmead Hospital, he was *temporarily absent from* a correctional centre at the time of his death.

2.4 The requirement that coroners examine deaths that occur while someone is incarcerated is important as a matter of public policy. It ensures appropriate and independent scrutiny of the considerable powers that CSNSW has over inmates. It also ensures appropriate and independent scrutiny is given to the care provided by Justice Health which is responsible for the provision of medical and psychiatric services to inmates. The mandatory nature of inquests into the deaths of CSNSW inmates recognises that people retain their fundamental human dignity even when incarcerated.

2.5 An investigation into Alfie's death was conducted by the NSW Police Force (**NSWPF**) and the coronial team assisting the inquest, and a significant volume of evidence was obtained. This material was tendered at the commencement of the inquest in the form of a brief of evidence. This material provided answers to many of the issues to be explored in the

inquest. However, to the extent that further evidence in relation to discrete issues was required, further material was sought and tendered, and oral evidence heard, during the inquest. While I am unable to refer specifically to all the available material in detail in my findings, it has been comprehensively reviewed and assessed.

2.6 In Alfie's case, his identity, and the date, place, and cause of his death were not in dispute. For this reason, the only issues explored at the inquest (separate to the systemic issues arising from all four deaths considered in conjunction) related to the manner, that is, the circumstances, of Alfie's death. These were:

(i) Mr Davidson's classification and movement through custody in the period 29 January 2017 - 9 February 2018.

(ii) Mr Davidson's contact with Justice Health in the period 29 January 2017 – 9 February 2018 in relation to a diagnosis of drug induced psychosis.

(iii) Mr Davidson's alleged consumption of alprazolam (via another inmate) and crystal methamphetamine whilst in MRRC G Block around 8 and 9 February 2018.

2.7 While the above issues guided the coronial investigation and shaped the conduct of the inquest, an inquest can tend to crystallise the areas that need attention. I intend to deal with the most important issues as they emerged during the proceedings under the broad headings below.

3. Alfie's background

3.1 While any inquest inevitably focuses on the circumstances of the death of a person, it is important to recognise and acknowledge the life of the person the subject of the inquest in a brief and hopefully meaningful way, to better appreciate what their life, and their loss, meant to those who knew and loved them.

3.2 Alfie was born on 7 October 1963 and was 54 years old when he died on 9 February 2018. He was the eldest of 3 children born to his parents' marriage. Alfie was survived by his mother, his sister, and his brother. He was close to his family, particularly to his mother, who he would see 3-4 times a week and speak with at least daily. Alfie was an intelligent man and a talented dancer. He worked for several years in information technology for a health insurance company. Alfie's family remember a gentle and forgiving man who loved his family and loved his cats and was, in their experience, kind and tolerant of others.

3.3 Alfie faced hardship during his life, including bullying and homophobic abuse. He was diagnosed with HIV in 1988 and this illness eventually led to deterioration in his cognitive functioning. In 2004 Alfie was diagnosed with AIDS dementia complex. He commenced on antiretroviral therapy and over the course of the next three years his cognitive functioning appears to have improved significantly. But even with this improvement, Alfie still needed support from his family at times. While he lived independently, the family would often cook and eat together. They would help Alfie with shopping, with cleaning his apartment, and they would take him to appointments, particularly at times when he was experiencing depression.

3.4 By 2017 Alfie was living at Maroubra. He reported to his sister being harassed by a neighbour, in part because of his sexuality.

3.5 On New Year's Eve 2017 Alfie was involved in an altercation with, it seems, this neighbour. Alfie was alleged to have approached the neighbour with a syringe filled with something that looked like blood and to have threatened to give him AIDS before making six attempts at stabbing the neighbour with the syringe.

3.6 On 1 January 2018 Alfie was arrested and charged with attempting to cause grievous bodily harm to a person with intent and being armed with intent to commit an indictable offence. These were only the second set of charges on Alfie's criminal record. Back in 2011 a single count of possess prohibited drug had been dismissed pursuant to s10 of the *Crimes (Sentencing Procedure) Act* 1999.

3.7 Alfie was refused bail. On 2 January 2018 he was received into the MRRC. While Alfie reported his AIDS Dementia Complex diagnosis during an early mental health assessment at MRRC, he was cleared for normal cell placement.

3.8 CSNSW records suggest that Alfie had an argument with a cellmate on 14 January 2018 which necessitated a change in housing for him. Alfie reported to his sister being scared and intimidated by a cellmate, but it is unclear if this was the same person that Alfie was arguing with. Alfie was moved to G Block, cell 396 where he remained until he died.

3.9 Alfie kept in regular contact with his family from prison. He would call his mother often and his sister visited him 6 times in January 2018. Alfie was also in contact with his solicitor. He had a Supreme Court bail application listed on 8 March 2018. Unfortunately, Alfie died before his application was heard.

4. Mervyn Davidson's background

4.1 Mervyn Davidson had a dysfunctional upbringing and his early and ongoing exposure to violence, and to alcohol and drug abuse, resulted in significant and chronic problems. He had a lengthy drug and alcohol history dating from childhood, and although he had attempted drug and alcohol rehabilitation in the community, he had failed to complete any programs. Cognitive testing performed in anticipation of sentencing proceedings in early 2018 placed him in the bottom 1% of the population in terms of his intellectual capacity.

4.2 Mr Davidson had no mental health history in the community and no history of involvement with mental health services prior to his entry into custody in January 2017.

4.3 Mr Davidson had an extensive criminal and custodial history. His criminal history commenced with Children's Court proceedings in 1990. By 2018 he had spent most of his adult life in custody. He was clearly institutionalised.

4.4 In 2014 Mr Davidson was sentenced to a 4-year term with a non-parole period of 2 years for the offence of aggravated break and enter and commit serious indictable offence in company. On 8 November 2016 he was released to parole from Parklea Correctional Centre.

5. Mr Davidson's movement through custody: 29 January 2017 – 9 February 2018

5.1 On 29 January 2017, while still on parole, Mr Davidson attacked a cashier in a supermarket with a baseball bat. He was later found to be intent upon robbing the supermarket while experiencing a drug induced psychosis. The supermarket cashier was quickly rendered unconscious, but Mr Davidson then kicked her as she lay prone on the ground, as he tried to access the cash register. Mr Davidson also attacked others who came to her aid although eventually some workers and shoppers were together able to restrain him until Police arrived.

5.2 This event was the most physically violent in Mr Davidson's criminal history up until that point in time. Otherwise, the vast majority of Mr Davidson's offending behaviour had been drug-related but without such terrible violence.

5.3 Mr Davidson was arrested and taken to Lake Illawarra Police Station. While at the police station he assaulted a police officer while being moved from the dock to a cell and had to be restrained by his adult son and a support person.

5.4 On 30 January Mr Davidson was received into the MRRC. The same day, he initiated a fight with another prisoner in the reception holding yards at the MRRC involving repeated blows to his victim's head.

5.5 After he was assessed at Reception Mr Davidson was placed in a camera observation cell. On the relevant Health Problem Notification Form (**HPNF**), dated 30 January 2017, the Justice Health nurse who assessed him recorded *cannot guarantee safety of self or others* and *mentally unwell*. In terms of cell placement, she recommended *assessment cell – must be one out*. Mr Davidson was referred to the Risk Intervention Team (**RIT**).

5.6 On 1 February 2017 Mr Davidson was cleared from the RIT list and was recommended for a normal cell placement, which permitted him to be placed one out, two out, or in shared accommodation. An alert for *history of self-harm incident* also appears to have been placed on the CSNSW Offender Integrated Management System (**OIMS**). The same day, Mr Davidson violently assaulted his new cellmate, choking him until the cellmate fell unconscious to the ground, and then kicking him. Initially Mr Davidson continued to attack his cellmate even in the presence of the CSNSW staff member who first responded. It took the attendance of the Immediate Action Team (**IAT**) before CSNSW staff could safely enter the cell and remove Mr Davidson.

5.7 Mr Davidson's attack on his cellmate was described by one of the psychiatrists who later assessed him as a *near homicide*. On 9 March 2018 Mr Davidson was sentenced to an aggregate period of imprisonment of 11 years, with a non-parole period of 7 years and 8 months in relation to this incident as well as the assaults on the supermarket employee and the police officer at Lake Illawarra police station.

5.8 Not surprisingly, due to the 1 February 2017 choking attack on this new cellmate, Mr Davidson was identified as a person of interest to the Extreme Threat Inmate Management Committee (**ETIMC**). From 2 February 2017 Mr Davidson was placed in segregated custody. He was subject to mental health review over the following weeks, with a diagnosis made of *possible underlying psychotic illness (1st presentation, untreated)*.

5.9 The segregation order was revoked on 22 March 2017 for Mr Davidson to enter the MRRC's Mental Health Screening Unit (**MHSU**). On 13 April 2017, Mr Davidson struck another inmate several times while in the MHSU. However, Mr Davidson's mental health eventually stabilised and by the end of April 2017 he was cleared from the MHSU to his gaol of classification. The MSHU Discharge Management Plan said Mr Davidson's psychotic

symptoms resolved with treatment (olanzapine 15mg nocte and mirtazapine 30mg nocte). The recommendation was made that Mr Davidson be placed in a one out cell because of his aggression towards others.

5.10 On 2 May 2017 Mr Davidson moved out of the MHSU to another pod at the MRRC.

5.11 In June 2017 Mr Davidson transferred to Lithgow Correctional Centre (**Lithgow CC**). He returned occasionally to the MRRC, for court appearances. On the available records he did not come to the attention of CSNSW or Justice Health staff due to violence or aggression or threats to himself or others between his release from the MHSU and the attack on Alfie in February 2018, over 6 months later.

6. Mr Davidson's contact with Justice Health: 29 January 2017 – 9 February 2018

6.1 After the assault on his cell mate on 1 February 2017, there were understandable concerns about Mr Davidson's mental state, his risk of harm to himself and others, and his unpredictable behaviour.

6.2 Between 2 February 2017 and his entry to the MHSU, while still in segregated custody, Mr Davidson was seen by a consultant psychiatrist on 6 February 2017, 13 February 2017, 20 February 2017, 27 February 2017, 6 March 2017, 13 March 2017, and 21 March 2017. On his transfer to the MHSU Mr Davidson was seen by psychiatrists on 23 March 2017, 27 March 2017, 30 March 2017, 6 April 2017, 13 April 2017, and 27 April 2017. While in the MHSU, Mr Davidson was diagnosed with a drug induced psychosis, poly-substance abuse disorder, and antisocial personality disorder. This was thought to be Mr Davidson's first presentation with a psychotic illness.

6.3 Mr Davidson was seen by psychiatrist, Dr Antonio Simonelli, on 12 May 2017. Dr Simonelli confirmed the diagnosis of drug induced psychosis, which had resolved, but which nonetheless warranted continuation of the antipsychotic medication olanzapine and the anti-depressant mirtazapine. This was Mr Davidson's last contact with a psychiatrist prior to Alfie's death.

6.4 In terms of Mr Davidson's psychiatric progress across the period, the Court had the benefit of a report from an independent expert, Forensic Psychiatrist Dr Andrew Carroll. Dr Carroll reviewed the material within the brief outlining the assessment and care of Mr Davidson between 29 January 2017 and the attack on Alfie on 9 February 2018. In Dr Carroll's opinion:

Mr Davidson was thoroughly reviewed by a number of consultant forensic psychiatrists following the initial violent attack on 1 February 2017 [the earlier attack on his cellmate]. Comprehensive reviews including the careful taking of histories, assessments of mental state and obtaining of collateral information were completed.

Ultimately he was treated with antipsychotic medication which can sometimes be indicated as a short term (months rather than lifelong) treatment measure for methamphetamine induced psychosis.

His symptoms responded well to a relatively low dose of olanzapine. The consensus was that the episode was considered to be substance-induced psychosis rather than indicative of emerging schizophrenia. This consensus diagnostic opinion was in my own opinion well-founded and appropriate, given what was known at the relevant time. It followed several thorough psychiatric evaluations and consideration of the collateral data (both clinical and that obtained from family).

6.5 Dr Carroll concluded that the decision to discharge Mr Davidson back to primary healthcare (rather than continue with specialist psychiatrist reviews) in May 2017 was entirely consistent with usual practice in Australia. However, in the opinion of Dr Carroll, although it was not necessary for any further planned psychiatrist review to occur after 12 May 2017 given the picture of clinical stability at that point, it was important for Justice Health to arrange further evaluations by primary health services (for example, prison general practitioners) in order to monitor the ongoing clinical indication (if any) for Mr Davidson's antipsychotic medication, olanzapine. This was also necessary to ensure that appropriate physical health monitoring was in place to gauge Mr Davidson's response to his medication and any potential side effects.

6.6 Mr Davidson had contact with Justice Health after his release from the MHSU. However, Mr Davidson initiated this contact, which was for minor matters to do with his physical health. There does not appear to have been any ongoing scheduled review of Mr Davidson's continued need for his antipsychotic medication nor any metabolic monitoring. Despite this, there is nothing within the Justice Health or CSNSW records to suggest that Mr Davidson's behaviour or health gave cause for concern in the period between May 2017 and the attack on Alfie on 9 February 2018. Mr Davidson was next due for routine monitoring by a psychiatrist at about 12 months after symptom resolution.

6.7 Dr Carroll suggests that ideally Mr Davidson should have had periodic review (possibly by a GP) and also have received metabolic monitoring in the period between May 2017 and 9 February 2018. The evidence was, that in response to recommendations in another inquest unrelated to Alfie's death, Justice Health has since established a metabolic monitoring alert system and clinics to conduct such monitoring.

7. Events leading up to 9 February 2018

7.1 Mr Davidson's sentencing proceedings were listed at the District Court in Wollongong on 8 February 2018.

7.2 A nursing note on Mr Davidson's file for 26 January 2018 noted that a bag (presumably containing medication and/or medical files) was packed for Mr Davidson's transfer the next day from Lithgow CC to the MRRC, but that Mr Davidson was not seen by nursing staff that day.

7.3 A nursing note for 27 January 2018 recorded Mr Davidson's arrival at the MRRC but said that he was *not seen*. The entry reads *for review tomorrow* (that is, 28 January 2018). Although there is no entry in the handwritten nursing notes for 28 January 2018, an entry for 28 January 2018 on Justice Health's Patient Administration System (**PAS**) records *NIL Issues or concerns voiced ATOR* [at time of review].

7.4 At the time Mr Davidson attacked Alfie he was classified as an A2 maximum security prisoner. This means that under the *Crimes (Administration of Sentences) Regulation 2014* Mr Davidson was in a category of inmates who were required to be confined at all times by a security physical barrier that includes towers, other highly secure perimeter structure or electronic surveillance equipment. While an inmate's classification determines the type of facility within which an inmate can be housed it does not determine where within that facility the inmate will be accommodated.

7.5 On 28 January 2018 Mr Davidson was moved to G Block Pod 12 cell 397, where he remained until Alfie's death. Mr Davidson was required to be housed one out, meaning he was not to be placed with another prisoner in his cell. Since 14 January 2018 Alfie had been housed in cell 396, the cell adjoining Mr Davidson's.

7.6 Although Mr Davidson was housed one out, at the time of Alfie's death, he had been stepped down in a way that permitted him to mix with other prisoners during the day. Despite the two assaults on other inmates in 2017, there were no alerts on CSNSW's

Offender Integrated Management System (**OIMS**) that reflected the risk that Mr Davidson posed to others.

8. Events of 9 February 2018

8.1 Although Mr Davidson's sentencing proceedings were listed on 8 February 2018, he was unwell that day, so proceedings were adjourned.

8.2 On 9 February 2018, Alfie rang his mum and talked about having had a new cellmate transferred into his cell. He didn't raise any other issues with her. This would be the last conversation Alfie had with a family member.

8.3 As at February 2018 G Block Pod 12 had a capacity of 86 prisoners. One witness recalls about 70 inmates being held there at the time, although a precise figure was not available. There appear to have been 3 CSNSW staff supervising Pod 12 at the time of Mr Davidson's attack on Alfie.

8.4 At about 12:49pm CSNSW staff started to unlock the cells of G Block, Pod 12 so that prisoners could be free to move about the common area of the Pod. Along with the other inmates, Alfie and Mr Davidson were able to move about and in and out of the open cells.

8.5 At some point during the afternoon another inmate heard Mr Davidson say, *Yeah, I will fucking kill them all*.

8.6 At about 1:52pm Alfie entered cell 396. He shut the door behind him. At this point Mr Davidson was standing on a nearby landing. Shortly afterwards Mr Davidson opened the door to cell 396, walked inside and closed the door behind him. In the later Supreme Court proceedings, Justice Davies placed some weight on Mr Davidson's actions in closing the door which, his Honour said, *leads strongly to an inference that he knew that what he was doing or was going to do was wrong.*

8.7 At about 1:56pm another inmate approached cell 396, opened the door, looked inside and then closed the door and walked away.

8.8 At about 1:57pm the door to cell 396 opened from inside with some movement visible within the cell but not clear enough to determine what was happening inside.

8.9 A short time later the door to cell 396 again closed from the inside. The door opened from inside on a couple of occasions from 2:13pm through to 2:15pm but it was not until 2:18pm that Mr Davidson left cell 396 and closed the door behind him.

8.10 Mr Davidson then entered cell 397 (where he was housed) and shut the door behind him.

8.11 Mr Davidson did not remain in his cell for long. At 2:22pm he left his cell and opened the door of cell 396 before re-entering his cell a short time later.

8.12 Around this time another inmate walked past the open door of cell 396 and discovered Alfie. This man alerted CSNSW Officer McElroy. The first responding officer is visible on CCTV from within the Pod walking towards cell 396 at 2:24pm.

8.13 After Alfie was discovered, an ambulance was called. He initially responded to treatment and was taken to Westmead Hospital. However, by about 6:00pm it was clear that Alfie was not going to recover from the injuries he sustained in the attack by Mr Davidson and a decision was made to take him off a ventilator. Alfie died at 6:25pm that night.

8.14 On the evidence within the brief and as accepted in the Supreme Court proceedings, there was no history of conflict or animosity between Mr Davidson and Alfie before the attack.

9. Events following Alfie's death

Charges

9.1 On 10 February 2018, Mr Davidson was charged with Alfie's murder. He entered a plea of not guilty on the grounds of mental illness.

Autopsy

9.2 On 13 February 2018 Forensic Pathologist, Dr Sairita Maistry, conducted an autopsy. Dr Maistry found evidence of neck trauma/compression with signs of asphyxia. In addition, there was blunt chest trauma evidenced by extensive subcutaneous haemorrhages and multiple bilateral posterior rib fractures.

9.3 Dr Maistry recommended that the cause of Alfie's death be recorded as the combined effects of neck compression and blunt chest trauma.

Mervyn Davidson's alleged consumption of illicit drugs prior to the assault on Alfie

9.4 The issue of Mr Davidson's intoxication at the time of the attack on Alfie arose when he was interviewed by psychiatric experts, Dr Adam Martin and Dr Olav Nielssen, for the purpose of the criminal proceedings relating to Alfie's death.

9.5 In an interview with each psychiatrist Mr Davidson referred to his use of drugs while at the MRRC before the attack on Alfie. For instance, Mr Davidson told Dr Martin that he used

drugs in gaol whenever he could and that he obtained them from other inmates. He said that he had taken five alprazolam (Xanax) tablets on the morning of the attack, and that he had also smoked some ice that morning. He thought he may have also taken ice the previous day. Mr Davidson gave a similar account to Dr Nielssen. It was a topic that Mr Davidson returned to in his oral evidence in the Supreme Court proceedings.

9.6 Although a urine sample from Mr Davidson was collected on 12 February 2018 it did not show any positive results for either amphetamines or benzodiazepines, although the sample was collected 3–4 days after the alleged consumption of the drugs. Ultimately it was not possible to be confident of Mr Davidson's account of his alleged drug use.

Change in diagnosis

9.7 In the Supreme Court proceedings, each expert highlighted the difficulties involved in trying to distinguish between a drug induced psychosis versus schizophrenia.

9.8 Dr Nielssen observed that the neurological injury caused by Mr Davidson's methamphetamine use in the months before his initial offences (the assault on strangers at ALDI) may have triggered the onset of what, by the time of the assault on Alfie, was thought to be a chronic form of schizophrenia. Dr Martin said that it is often difficult to differentiate between a brief drug-induced psychotic disorder compared with a long-term schizophrenic disorder, particularly when there has been sustained use of methamphetamine and other drugs.

9.9 Both Dr Nielssen and Dr Martin concluded that Mr Davidson had developed schizophrenia. Both experts believed that Mr Davidson's drug use was part of his mental illness, but that drug use alone did not explain the symptoms that continued, even after Mr Davidson killed Alfie and returned to segregated custody (although his symptoms were then better managed).

9.10 Expert Forensic Psychiatrist, Dr Andrew Carroll, agreed there were challenges involved in diagnosing schizophrenia in a patient who also has a history of methamphetamine use. He told the Court:

> *Reliable differentiation between these two diagnostic possibilities, based purely on a cross-sectional assessment of a given patient, is not possible: the best that can be done therefore in a patient with a known history of methamphetamine use and onset*

of new psychotic symptoms, is to note that a range of diagnostic possibilities exists and follow up will be required to clarify matters further.

To further cloud the picture, longitudinal research dating back over a number of decades has also shown that it is not uncommon for patients who use methamphetamines to initially present with brief substance-induced psychotic episodes but eventually for their clinical picture to evolve into a psychotic illness that remains evident even when they are not using substances…such an illness can manifest as psychotic relapse even in the complete absence of further use of methamphetamine and therefore would meet criteria for schizophrenia.

9.11 This expert evidence provides important context to Mr Davidson's progress in custody. It explains how what is now understood to be schizophrenia was initially thought to be a drug induced psychosis.

Criminal proceedings

9.12 On 14 August 2019, his Honour Justice Davies in the Supreme Court returned a verdict of not guilty to murder but guilty to manslaughter. His Honour emphasised that although Mr Davidson had an underlying mental illness (schizophrenia) his assault upon Alfie was caused by the consumption of the drugs he said he obtained and consumed while at the MRRC in the days leading up to Alfie's death.

9.13 His Honour determined:

The principal problem for the accused is establishing on the balance of probabilities that the killing of the deceased was brought about by the accused's mental illness and not as a result of his ingestion of the drugs. Two things in particular show that the accused has failed to discharge this onus.

First, his evidence both to Judge Haesler and at the present trial was that since he had been medicated with Zyprexa and Avanza the voices he had been hearing had stopped. This was also what he told the psychologist Emma Huebner on 2 December 2017. This was some indication that his schizophrenia was reasonably well controlled at the relevant time.

Secondly, at the same time he gave evidence in the present trial that he knew if he took ice he would or could get violent because that was what had happened previously.

Those two matters point strongly to a conclusion that the cause of the offending was not the underlying schizophrenia but the ingestion of the drugs…

Because the onus is on the accused to establish the mental illness defence, it is his responsibility to show that it was the mental illness rather than the drugs that was operating on his actions. For the reasons just given, the evidence points the opposite way.

9.14 His Honour rejected the defence of mental illness but was not satisfied of all the elements of murder, as his Honour could not be satisfied beyond reasonable doubt that the accused formed the requisite intention by reason of his self-induced intoxication with the drugs. However, Justice Davies was satisfied of all the elements of manslaughter and so returned a verdict of not guilty to murder but guilty of manslaughter.

9.15 On 14 February 2020, Mr Davidson was sentenced to 11 years imprisonment for manslaughter with a non-parole period of 7 years.

10. Findings required by s81(1) of the Act

10.1 I make the following findings in relation to AP's death.

Identity

The person who died was AP.

Date

AP died on 9 February 2018

Place

AP died at Westmead Hospital

Cause of death

AP died of the combined effects of neck compression and blunt chest trauma.

Manner of death

AP died as a result of an assault inflicted upon him by a known person while he was in the lawful custody of CSNSW and housed at the MRRC.

11. Recommendations pursuant to s82 of the Act

11.1 Because the issues raised by the circumstances of Alfie's death overlap with those raised by the deaths of the other three inmates considered in conjunction with this inquest, no recommendations will be made that are specific to this matter but will instead be made collectively in relation to all matters.

12. Close of Inquest

12.1 I thank Counsel Assisting, Donna Ward SC and Anna Payten, and their instructing solicitor, Emily Burston of the Crown Solicitor's Office, for all the assistance they have provided to me in the preparation and conduct of this inquest. I also thank Detective Chief Inspector Karl Leis for the very comprehensive investigation he conducted into the circumstances of Alfie's death.

12.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to Alfie's friends and family.

12.3 I close this inquest.

Judge Kasey Pearce

Deputy State Coroner

13 May 2026