CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ryan Fennell
Hearing dates:	5 May – 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 – fatal assault by cellmate – treatment and monitoring of inmates with mental illness
File number:	2019/000110322
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 and the South Eastern Sydney Local Health District A Terracini, instructed by S Naz of Legal Aid NSW representing the Senior Next of Kin R Deppeler, instructed by M Burns of McNally Jones Staff Lawyers representing former Correctional Officer Bradley Kisbee C Magee, instructed by S Wallace of Moray & Agnew for Dr Casimir Liber K Doust of the NSW Nurses and Midwives Association for Registered Nurse Jilane Sarjeant

Non-publication order:	On 14 May 2025 a non-publication order was made pursuant to section 74(1) of the Coroners Act 2009 (NSW) in relation to some evidence in this inquest. A copy of this order is on the Registry file.
Findings:	**Identity** The person who died was Ryan Fennell. **Date** Ryan Fennell died on 8 April 2019. **Place** Ryan Fennell died at the Metropolitan Remand and Reception Centre in Silverwater NSW 2128. **Cause of death** Ryan Fennell died due to the combined effects of neck compression and blunt force craniofacial trauma. **Manner of death** Ryan Fennell died as a result of an assault inflicted upon him by a known person while he was in the lawful custody of CSNSW.

Table of Contents

1. Introduction

1.1 At the time of his death, Ryan Fennell (**Ryan**) was an inmate at the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater. He died on 8 April 2019 due to a severe and sustained assault perpetrated on him by his cell mate, Matthew Macguire. He was 39 years old.

1.2 On 2 March 2019 Ryan was arrested on assault charges. He was refused bail. On 7 March 2019 he was transferred to the MRRC, where he remained until he was transferred to Westmead Hospital for a medical procedure on 26 March 2019.

1.3 Matthew Macguire had a lengthy forensic and psychiatric history. He had come from a very traumatic background and had been diagnosed with a number of mental health issues. He had a history of self-harm and of harming others. Matthew Macguire had been a remand inmate since 9 November 2018. After a period of time in the Mental Health Unit (**MHU**) of Long Bay Hospital (**LBH**), he been transferred to the Mental Health Intensive Care Unit (**MHICU**) at Prince of Wales Hospital (**POWH**). He returned to the MRRC on 29 March 2019 and was allocated to cell 38 in Darcy 1.

1.4 When Ryan returned to the MRRC from Westmead Hospital on the afternoon of 8 April 2019 he was allocated a bed in cell 38 with Matthew Macguire. Within hours of his return, Ryan was attacked and killed by his cell mate.

1.5 The inquest into Ryan's death took place in conjunction with inquests into the deaths of three other inmates, who died while in the custody of Corrective Services NSW (**CSNSW**) between 2018 and 2020: AP, 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 issues common to the four deaths.

1.6 By the time these proceedings were heard, many years had passed since Ryan'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 came to an end. Ultimately, further delay arose because

Ryan's death was investigated as part of the wider group of matters that the Court has considered.

1.7 Ryan is survived by his mother, Elizabeth, his brother, Clayton, and his sister, Nicole. I acknowledge the tragic circumstances of Ryan's death and the devastating impact that losing Ryan has had on his family. On behalf of the Coroners Court of NSW, I extend my deepest sympathies to Ryan's 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*.

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 power that CSNSW has over inmates. It also ensures appropriate and independent scrutiny is given to the actions of Justice Health which is responsible for the provision of medical and mental health 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 Ryan'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 additional 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 Ryan'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 related to the manner of Ryan's death.

2.7 A list of issues was prepared before the proceedings commenced. These issues were:

(i) Matthew Macguire's classification and movement through custody in the period 9 November 2018 - 25 March 2019 and 27 March 2019 - 8 April 2019;

(ii) Matthew Macguire's assessment at the Prince of Wales Hospital between 25 March 2019 – 27 March 2019, leading to an assessment that he was not then mentally ill, not detainable under the Mental Health Act 2007 and would not benefit from mental health admission.

(iii) What became of the Prince of Wales Hospital discharge summary for Matthew Macguire once received at the Medical Appointments Unit, Justice Health, on 28 March 2019?

(iv) How did Matthew Macquire end up sharing a cell with another inmate, particularly in light of observations recorded by various RIT (Risk Intervention Team) members on 31 March 2029, 2 April 2019, 5 April 2019 and 7 April 2019?

(v) How did Ryan Fennell come to be placed in Cell 38 with Matthew Macguire following Ryan Fennell's discharge from Westmead Hospital on 8 April 2019?

(vi) Why did no one on C Watch observe from the camera footage, the assault by Matthew Macguire upon Ryan Fennell, stretching across a period of almost one hour?

2.8 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. Ryan'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, means to those who knew and loved them.

3.2 Ryan was born on 5 October 1979 and was 39 years old when he died on 8 April 2019. He lived with several chronic illnesses which made his life challenging in many respects. He struggled with addiction to both illicit drugs and alcohol and developed hepatitis C and cirrhosis of the liver. He had a congenital heart disease and emphysema. Ryan also suffered from schizophrenia.

3.3 Because Ryan's physical and mental health could be poor, he was frequently hospitalised. He was sometimes required to undergo treatments, including blood transfusions, endoscopies and other interventions, which could be especially difficult for Ryan because poor mental health impacted his ability to tolerate the tests and treatment necessary to improve his physical health. The medical records suggest that Ryan's schizophrenia was not always well controlled, in part because he was not always compliant with his medication.

3.4 Ryan first encountered the criminal justice system at a young age. His first time in custody, under a periodic detention order, occurred in 1999. His subsequent involvement with the criminal justice system was predominantly for less serious offences and resulted in community-based sentences and on occasion, diversion under the Mental Health Act, although he was sentenced to a full-time custodial sentence in 2011 for several robberies, as well as other offences.

4. Matthew Macguire's background

4.1 Matthew Macguire had a history of childhood trauma and sexual abuse which likely had an early and devastating impact on him and contributed to his disturbed behaviour as an adult. He had a long criminal history and a pattern of aggressive and manipulative behaviour.

4.2 Mr Macguire first had contact with the criminal justice system was when he was 12 years old. He was thereafter frequently before the courts. He was often dealt with under the *Mental Health Act* but inevitably reoffended and circled back through the criminal justice system. Mr Macguire had limited support in the community and, it seems, was often homeless when not in custody.

4.3 Mr Macguire's first contact with mental health services was at the age of 16. He had an extensive psychiatric history with more than 20 admissions at Wagga Wagga, Cumberland and Bloomfield Hospitals. He had made multiple attempts to end his life. There was some suggestion in Mr Macguire's CSNSW and psychiatric records that he may also have had a mild intellectual disability. He had a lengthy history of addiction to illicit drugs. At some point he had been placed under the care of the Public Trustee and Public Guardian.

4.4 Justice Health clinicians had diagnosed Mr Macguire as having schizophrenia. A June 2018 discharge summary from POWH referred to Mr Macguire's background diagnosis of schizoaffective disorder with residual symptoms, antisocial personality traits, PTSD secondary to prolonged childhood sexual abuse by extended family, comorbid polysubstance use, a significant forensic history, numerous attempts on his life with high lethality means and a long history of aggression/violence in mental health and forensic facilities.

4.5 There is no doubt that Mr Macguire presented a complex clinical puzzle for clinicians and a behavioural problem for police, hospitals, and CSNSW.

5. Ryan's entry into custody – 7 March 2019

5.1 On 2 March 2019, while subject to a 12-month community corrections order, Ryan was arrested. Police took him to Bankstown Hospital because he was vomiting blood. During this hospital admission, Ryan's principal diagnosis was chronic pancreatitis, emphysema and portal hypertension. It was noted that Ryan remained psychotic and that his schizophrenia was only partially treated. On discharge it was noted that Ryan required monitoring by the gastroenterology clinic.

5.2 On his release from Bankstown Hospital, Ryan was remanded in custody and remained in the 24-hour Surry Hills Court Cell Complex until his transfer to MRRC on 7 March.

5.3 On his reception into MRRC, Ryan completed a Reception Screening Assessment (**RSA**) with a Justice Health nurse, who noted his chronic pancreatitis, cirrhosis of the liver and portal hypertension. Ryan was placed on a waiting list to see the GP, the mental health team, and the detox team. The Justice Health nurse completed a Health Problem Notification Form (**HPNF**) that advised that Ryan was to be *housed in a camera cell 24hours/7 days* on the Darcy Wing until cleared.

5.4 Ryan saw a GP the following day, 8 March 2019, when he was observed to have an oesophageal stricture and oesophageal ulcer. A plan was made for Ryan to remain on a fluid diet with no solids and to receive gastroenterology follow up. The GP noted that Ryan needed to remain in a medical observation cell, with urgent medical review if there was any abdominal pain or vomiting. The GP completed a clinical certificate requesting that Ryan be provided with a therapeutic diet. Further HPNFs were completed on 11 March and 15 March to the effect that Ryan was to be housed in a camera cell 24 hours/7 days until cleared.

5.5 Unfortunately, Ryan's physical health deteriorated, possibly because, notwithstanding the directions on the HPNF that he be on a fluid diet only, he continued to access and eat solid food on various occasions across the next week.

5.6 Ryan was involved in an incident with another inmate on 16 March 2019 which required a brief trip to Westmead Hospital for medical treatment. Ryan's medical records show that after his return from hospital he continued to complain about being on a fluid diet. It seems that his mental health fluctuated and that at times he was unable to appreciate that he was physically unwell and why he needed to be on a fluid diet.

5.7 It is clear from Ryan's medical notes that by 15 March 2019 the Justice Health GP was concerned that Ryan had still not had bloods taken to check his iron levels and that he continued to be provided with solid food. The GP also appeared worried about Ryan's mental health because he had said he needed to eat to purge and then he would die like Jesus Christ. The GP changed the priority level of Ryan's mental health review to priority 1, which carried a recommended timeframe of review within 1-3 days. Unfortunately, the evidence suggests that Ryan was not reviewed by a psychiatrist between this date and his death.

5.8 The transfer to Westmead occurred because Westmead Pathology contacted Justice Health to advise that Ryan's most recent pathology results were abnormal. Ryan was increasingly unwell. He was transferred to Westmead Hospital for an endoscopy and other investigations.

5.9 Ryan remained at Westmead Hospital until 8 April 2019, when he returned to the MRRC in the afternoon. On his return Ryan was required to be housed in a camera cell for medical observation.

6. Mr Macguire's movement through CSNSW custody 9 November 2018 – 25 March 2019

6.1 On 9 November 2018 Matthew Macguire was refused bail at Queanbeyan Local Court on charges of destroy/damage property and assault with an act of indecency, and was transferred to South Coast Correctional Centre (**South Coast CC**) Mr Macguire's CSNSW Inmate Profile Document (**IPD**) suggests his serious mental health issues made him unsuited to South Coast CC and an alert was placed on his IPD to this effect. On 14 December 2018, he was transferred to Goulburn Correctional Centre. A week later, on 21 December 2018, Mr Macguire was transferred to MRRC, due to the need for him to undergo a psychiatric assessment.

6.2 By December 2018 it was the opinion of the Justice Health psychiatrist involved in Mr Macguire's care that he had treatment resistant schizophrenia with a history of significant violence which was unpredictable. He was, at that point in time, thought to be psychotic and of significant risk to himself and others.

6.3 On 3 January 2019 a report from Mental Health Screening Unit (**MHSU**) Consultant Psychiatrist Dr Martin Reading, to the Statewide Clinical Director for Forensic Mental Health, reported that Mr Macguire had *a longstanding treatment resistant schizophrenia with multiple prior involuntary psychiatric admissions in the community*. He described Mr Macguire's mental illness as *characterised by both repeated unprovoked assaults of others and self-harm in response to his psychotic symptoms*. He opined that Mr Macguire could currently be considered a *mentally ill person* as defined in section 14 of the *Mental Health Act* 2007 and requested that an order be instigated to transfer Mr Macguire to a mental health facility.

6.4 Mr Macguire was managed under a Risk Intervention Team (**RIT**) Management Plan in an assessment cell until 24 January 2019 when he was scheduled as an involuntary patient and transferred from the MRRC to the Mental Health Unit (**MHU**) at LBH. While at LBH Mr Macguire was housed in a safe cell and treated for chronic treatment-resistant schizophrenia.

6.5 The Mental Health Review Tribunal (**MHRT**) considered Mr Macguire's case on 28 February 2019. The MHRT determined that he remained a mentally ill person and ordered that he remain detained in LBH.

6.6 Mr Macguire was reviewed by Dr Donna Button, forensic psychiatrist, on at least 9 occasions during the time he remained in the MHU at LBH: 25 January 2019, 29 January 2019, 4 February 2019, 11 February 2019, 25 February 2019, 5 March 2019, 14 March 2019, 19 March 2019 and 22 March 2019. In between psychiatric reviews, he remained under observation by mental health nurses.

6.7 By 5 March 2019 a plan had been developed for Mr Macguire to transfer to a forensic hospital placement in the long term. In the meantime, it was decided that he would remain at Long Bay Hospital under safe cell conditions.

6.8 A report by Justice Health Consultant Psychiatrist, Dr Gerald Chew, dated 15 March 2019, prepared at the request of a magistrate at Goulburn Local Court, outlined Mr Macguire's extensive psychiatric history. Dr Chew referred to Mr Macguire's primary diagnosis as being schizophrenia and said that at the time of assessment he was *acutely psychotic*. Dr Chew's opinion was that Mr Macguire was a *mentally ill person*. He was thought unfit to plead or stand trial.

6.9 In response to a request from the magistrate at Goulburn Local Court for a treatment plan, a further report was submitted to the Local Court. In this report, dated 21 March 2019, Dr Chew noted the only suitable community facility to which Mr Macguire could be discharged would be a gazetted mental health unit. Given he was in LBH, it was suggested that the closest gazetted mental health unit would be the Kiloh Centre at POWH. Mr Macguire was already known to the Kiloh Centre, including through admissions from 6 November 2017 until 7 January 2018 and from 22 May 2018 until 5 June 2018.

6.10 A further report to Goulburn Local Court from Dr Button and Dr Robert Reznik, dated 25 March 2019 referred to a diagnosis of chronic treatment resistant schizophrenia complicated by non-compliance and polysubstance abuse. This report also referred to other diagnoses including PTSD, intellectual disability and antisocial personality traits. The report writer listed Mr Macguire's medication as including monthly injections of the antipsychotic, Haloperidol (last given 18 March 2019) and daily oral Olanzapine (another antipsychotic) and oral Haloperidol (morning, evening and when required).

6.11 On 25 March 2019 Mr Macguire was released from CSNSW custody at LBH to POWH pursuant to an order made in the Local Court under s33(1)(b) of the *Mental Health (Forensic Provisions) Act 1990*. The order provided that if on assessment Mr Macguire was found not to be a mentally ill person or mentally disordered person within the meaning of the *Mental*

Health Act 2007, he was to be brought by a prescribed person back before a magistrate unless granted bail by a police officer.

7. Mr Macguire's time at Prince of Wales Hospital

7.1 Mr Macguire was difficult and dangerous while at POWH. Within hours of admission, he seriously assaulted a co-patient by strangulation, causing the co-patient to lose consciousness. Although there is some discrepancy in the way this event is recorded in police records compared to hospital records, on either account Mr Macguire clearly posed a danger to the other patient. Mr Macguire's behaviour in assaulting a co-patient was later described in his POWH discharge summary as *consistent with [his] historical pattern of deliberate assault on copatients to achieve seclusion which he prefers*.

7.2 Mr Macguire was moved into isolation at POWH. On 27 March 2019 he was reviewed by Dr Casimir Liber. Dr Liber's diagnosis drew upon his previous involvement with Mr Macguire including, amongst other things, his role in providing a second opinion to Dr Clive Stanton about Mr Macguire at the close of Mr Macguire's May/June 2018 admission. Dr Liber concluded that Mr Macguire's diagnosis was *consistent with severe cluster B personality disorder, predominantly antisocial, with chronic high risk of aggression and which is not driven by mental illness* (emphasis added). This was reportedly on a background of an *historical diagnosis of schizophrenia*.

7.3 Mr Macguire was ultimately assessed by Dr Liber as not mentally ill and therefore not detainable under the *Mental Health Act 2007.* Accordingly, Mr Macguire was discharged from POWH on 27 March 2019 and returned to the custody of police.

7.4 Dr Liber gave evidence at the hearing. His account provided important context to the decision making at POWH, and suggested how highly experienced experts in their own field can be worn down by the dangers and demands of trying to care for individuals such as Mr Macguire. In relation to Mr Macguire, Dr Liber explained:

> *It's profound – the concern that Dr Stanton,…Professor Large and I all had about this person. The static risk he has, which is profoundly, profoundly antisocial. He bore no remorse for his actions and had no qualms about being aggressive to people and/or property if someone didn't do what he wanted so if his needs weren't met or his perceived freedoms were curtailed.*

7.5 A file note from Dr Clive Stanton sets out the impression that the POWH team (not just Dr Liber) formed of Mr Macguire during earlier admissions, especially an admission that extended from 6 November 2017 – 7 January 2018:

> *My impression at that time was that his greatest psychiatric problem was with a severe Cluster B Personality Disorder with anti-social borderline and histrionic traits. My own opinion was that I wasn't convinced that he suffered from a major mental disorder at all but given that many previous psychiatrists had, I wasn't going to challenge the historical diagnosis of Schizo-Affective Disorder*

7.6 When Dr Liber was asked during the hearing whether it was possible that Mr Macguire had both a personality disorder and was in an acute phase of his mental illness particularly during the POWH May-June 2018 admission, he advised that both he and Dr Stanton *absolutely agreed that he did not have an acute mental illness*.

7.7 Dr Liber's assessment of Mr Macguire in March 2019 took place in the context of the assessments made of Mr Macguire during his previous admissions. In his statement, Dr Liber commented:

> *I had a lengthy discussion with Dr Large and Dr Stanton about Mr Maguire due to the level of risk we felt he posed to other people and what optimal treatment would comprise. We were in agreement that, based on his longitudinal history (including his admission in May 2018) and the direct observations of Mr Maguire by nursing and medical staff, Mr Maguire did not have an acute exacerbation of schizophrenia that required treatment but rather the predominant behaviour observed was more consistent with his personality.*

7.8 In his evidence, the court-appointed expert, Dr Andrew Carroll, acknowledged that Mr Macguire was diagnostically complex with, in his view, both a severe treatment resistant schizophrenia and a personality disorder with an entrenched propensity for high-risk behaviours. This, Dr Carroll conceded, made it difficult to tease apart the motivational drives for any given harmful behaviour.

7.9 Dr Carroll's view was that Mr Macguire remained in an active phase of his schizophrenia as of 27 March 2019. Dr Carroll suggested that it was not safe to assume that Mr Macguire's assault on the other patient at POWH was unrelated to active phase schizophrenia. He concluded there were reasonable grounds for believing that care, treatment and control of

Mr Macguire was necessary both for his own protection from serious harm and for the protection of others as of 27 March 2019. In the course of his oral evidence, he added:

> *I mean, he's on high – several high dose antipsychotic medications. He does have a personality disorder. No one's disputing that, but to say that every manifestation of disturbed behaviour or odd beliefs or disorganisation of thought and behaviour can be attributed to the effects of a personality disorder and trauma I think is misplaced.*

7.10 Importantly, Dr Carroll acknowledged in his written report that *judgments regarding detention of patients on an involuntary basis are inherently complex and are matters on which different psychiatrists may reasonably form divergent conclusions*.

7.11 It is accepted that Mr Macguire did have a range of very difficult comorbid personality disorders. There remains, however, disagreement between the forensic psychiatrists and the team at POW as to the possibility he was additionally unwell with schizophrenia in early 2019. Irrespective of his diagnosis, as Dr Carroll noted, Mr Macguire was a very complex and challenging patient to manage and probably fell within the relatively small number of patients who cannot be safely managed by non-forensic services, especially in a hectic public hospital. Dr Carroll and Dr Andrew Ellis in later evidence given concurrently noted that the typical amount of time available for an in-patient stay in a public hospital is nowhere near long enough to allow time for resolution of psychosis.

7.12 In any event, the diagnosis and treatment plan made at POWH did not have a direct effect on later decisions at the MRRC, because JH staff at the MRRC did not *sign off* on the POWH discharge summary until 6 April 2019.

8. The discharge summary from Prince of Wales Hospital

8.1 The discharge summary from POWH was apparently received by the Medical Appointments Unit at Justice Health on 28 March 2019, the day after Mr Macguire's discharge. It was then scanned so that it became available to Justice Health staff via the Justice Health Electronic Health Service (**JHeHS**).

8.2 The evidence suggests, however, that when the discharge summary was scanned into JHeHS, Mr Macguire had not yet been administratively received back into a CSNSW facility as he was not received into the Amber Laurel Correctional Centre (**ALCC**) until around 6 pm on 28 March 2019. This in turn meant that he did not have an active chart open with Justice Health at the time the POW discharge summary was scanned onto JHeHS earlier in the day.

9. Mr Macguire's movement through CSNSW custody 27 March 2019 – 8 April 2019

9.1 On 27 March 2019, the day of his discharge of POWH, Mr Macguire appeared before Waverley Local Court where he was refused bail. Because the effect of the s33 order made at Goulburn Local Court had been that Mr Macguire left the custody of CSNSW, when he was refused bail, he was treated as a new inmate by CSNSW.

9.2 A *New Inmate Lodgement and Special Instruction Sheet* and *Inmate Identification and Observation Form* (**IIO**) completed by CSNSW staff indicated that Mr Macguire had a mental health history, that he had returned from a s33 and that for these reasons he required immediate medical attention. It seems that he remained overnight at the 24-hour Surry Hills Court Cell Complex, until he was transferred to ALCC on 28 March.

9.3 Mr Macguire returned to the MRRC on 29 March 2019. He went through the reception screening process which involved interview and review by both CSNSW staff and by Justice Health staff.

Reception Screening Assessment by Justice Health

9.4 Justice Health Registered Nurse (**RN**) Jilane Sarjeant assessed Mr Macguire on 29 March 2019 on his reception into MRRC. RN Sarjeant took a set of general observations and asked Mr Macguire about his history. He volunteered some information about seeing a psychiatrist at Concord Hospital and being involved with community health but said he had not been in hospital in the previous six months.

9.5 Some information was auto-populated into the RSA form based on Mr Macguire's history with Justice Health. This included existing active allergies and health conditions but not current prescribing. Mr Macguire gave his own version of his current medications which did not reflect the actual prescribing that had been implemented at LBH's MHU and which had been left undisturbed at POWH.

9.6 Even though there was a computer terminal available to RN Sarjeant through which she could access JHeHS, her evidence was that she was not alerted to the need to check it. Instead, her assessment was dependent upon what Mr Macguire told her and what she observed during her assessment. She said she had no documentation available. Thus, RN Sarjeant was not aware of Mr Macguire's recent long admission at LBH (January to March

2019) nor the brief admission to POWH only a couple of days before she saw him (25-27 March 2019).

9.7 Even though her assessment was limited in this way, RN Sarjeant was nonetheless concerned by Mr Macguire's presentation and self-reported history, so she completed a mandatory notification form (**MNF**) for inmates at risk of suicide or self-harm. She placed waitlisted Mr Macguire on a waiting list for a Priority 2, semi-urgent review by a psychiatrist with a recommended timeframe of 4-14 days. RN Sarjeant also facilitated requests for Mr Macguire's health records from his community health team and completed a HPNF by which she notified CSNSW staff that Mr Macguire required *Assessment Cell – 24 hr Monitoring – Nil Sharps or Possessions – Safety Blanket – May Have Clothes*. The HPNF also required that Mr Macguire be reviewed by the Risk Intervention Team (**RIT**).

Cell placement decision

9.8 Mr Macguire was assigned to an assessment cell, cell 38 in Darcy 1. It is unclear how this happened. The CSNSW Checking Officer's Assessment and initial classification had not been completed. An interview for placement was apparently indicated based on the Offender Services & Programs (**OS&P**) screening of Mr Macguire in which he indicated concerns for his safety, although this does not appear to have occurred. No Reception and Accommodation Checklist was completed.

RIT Management Plans

9.9 Mr Macguire was reviewed by RIT on 31 March 2019, 2 April 2019, 5 April 2019 and 7 April 2019. The pro forma RIT management plan required that the cell placement selected should be the least restrictive, relative to risk. It included a note that *share accommodation should not be considered an option where a risk of harm to or from others is known to exist*. The tick box options included *normal cell*, *two-out placement*, *transition cell*, *assessment* and *other*. There was no tick box for a *one-out* placement.

9.10 Mr Macguire's RIT Management Plan of 31 March 2019 describes him as *mentally unwell, confused, hearing voices telling him to do self harm, inmate scratched names all over his both legs, arm, chest using a blade*. His cell placement was recorded as assessment or safe cell under constant electronic observation. The related Justice Health clinical note describes Mr Macguire as *currently a risk to self & others. Unpredictable & labile.* Despite this, Mr Macguire's priority for psychiatric review did not change. He remained a Priority 2 – semi

urgent referral to be seen within 4-14 days. Ultimately no psychiatric review of Mr Macguire occurred prior to Ryan's death.

9.11 On 1 April 2019 Mr Macguire was placed on a Special Management Area Placement Order (**SMAP**). In Mr Macguire's case the SMAP Order did not lead to any change in cell placement. He remained in an assessment cell in a pod containing SMAP and non-SMAP inmates.

9.12 The progress notes documenting the RIT review on 2 April 2019, refer to Mr Macguire having engaged in recent self-harm with a razor blade a few nights prior and record that he continues to display poor insight and judgment such that he was *unable to guarantee safety of self and others*. He was still awaiting psychiatric review. He was described as *slurred in speech at times*, as appearing disorganised and distracted, reporting ongoing auditory hallucinations, responding to internal stimuli, laughing inappropriately, and as being incoherent and illogical in thought form.

9.13 Another inmate was allocated a bed in cell 38 with Mr Macguire on 2 April. He moved out of the cell the next day and was transferred to another area.

9.14 The RIT Management Plan of 5 April 2019 describes Mr Macguire's presentation as *Inmate serious mental health and is unmedicated. Inmate is however co-operative & compliant.* Mr Macguire's cell placement is again recorded as *assessment*, although on this occasion there is no indication of the type or level of observations to be undertaken of Mr Macguire. The RIT case notes record that Mr Macguire *reported he is not receiving his medication* and that this was confirmed by the nurse. He was, however, thought able to access activities on the unit so that a decision was taken that he could be managed *normal by day* (**NBD**).

9.15 The records suggest that Mr Macguire was not receiving his daily oral medication (including anti-psychotics) from at least 28 March 2019 through until 5 April 2019. Medication was apparently charted for Mr Macguire on the afternoon of 5 April although what was prescribed was different to what was in place up until 28 March 2019. For instance, Mr Macguire was not recommenced on oral haloperidol (nor it would seem his blood pressure medication or proton pump inhibitor). So the prescribing belatedly introduced on 5 April 2019 amounted to a reduction in the antipsychotic medication (and other medication) he had previously been prescribed. It is unclear whether this was a considered decision. According to Dr Carroll, the Court appointed expert, Mr Macguire's *evident rapid*

deterioration in mental state (notwithstanding the presence of depot medication in his system) was entirely predictable in such circumstances.

9.16 The POWH discharge summary was apparently sighted by a Justice Health nurse from the MRRC on 6 April 2019, well over a week after Mr Macguire returned to the MRRC. However, this does not seem to have triggered a review to compare the medication belatedly prescribed only the previous day for Mr Macguire, against the medications previously prescribed during his long admission at LBH.

9.17 The RIT Management Plan of 7 April 2019 describes Mr Macguire as *Too unwell to assess. IAT required, thought blocking can't guarantee safety*. Again, *assessment* cell is indicated although no indication of the type or level of observations is included. The words *IAT required* are also recorded. The evidence was that IAT was an acronym for the Immediate Action Team. These are specially trained correctional officers who act as elite first responders to critical, high-risk, and volatile incidents within correctional facilities. Despite that notation on 7 April, another inmate was moved into cell 38 with Mr Macguire the same day.

9.18 In response to the indication that Mr Macguire was *Too unwell to assess*, Dr Carroll comments:

> *The notion of a person being 'too unwell' to undergo assessments is problematic: a proper risk assessment takes account of all the relevant information that is reasonably available. In circumstances such as this, this includes the information that a person is too unwell to coherently discuss their state of mind. A risk assessment can still be made in such circumstances and would of course be appropriately conservative.*

9.19 The evidence given in the inquest made clear that Justice Health staff understood that by ticking the cell placement option to indicate that an assessment cell was required, they understood that this would mean that Mr Macguire would be housed one out. This was not, however, the understanding of CSNSW staff, who understood that assessment cells could be either one out or two out.

9.20 With the exception of the reference in the RIT management plan of 7 April to *IAT required*, there were no alerts on the CSNSW's Offender Integrated Management System (**OIMS**) to the effect that Mr Macguire posed a risk to others, and nothing on the face of any HPNF or RIT Management Plan prepared in relation to Mr Macguire after he returned to the MRRC

on 29 March, to alert CSNSW staff to the fact that Mr Macguire was a risk to others and therefore must be housed one out, despite the fact that he posed a risk to others being recorded several times in Mr Macguire's Justice Health progress notes.

9.21 The RIT Management Plan dated 10 April 2019 (the day after Ryan's death) is the only occasion on which, next to the word *assessment* as type of cell, is also indicated *1 out*, that is, that Mr Macguire was to be the only person in the cell.

10. Events of 8 April 2019

10.1 Late in the morning of 8 April 2019 Mr Macguire was reportedly aggressive and threatening to bash his cellmate, Mr R, who had been placed in cell 38 with him the previous day. Mr Macguire apparently complained that Mr R was dirty in the cell and refused to clean up the mess on the floor. This incident occurred while the Senior Correctional Officer (**SCO**) for Darcy 1 was on lunch break and so the SCO for Darcy 2, John McKenzie, stepped in.

10.2 According to Mr McKenzie, the inmates agreed that they would take their grievance no further, if he would make alternative accommodation arrangements for Mr R. Mr McKenzie then moved Mr R to cell 39. He subsequently reported that at this time Darcy 1 assessment cells were at full capacity, although CSNSW has been unable to confirm this from their review of the records.

10.3 By this time Ryan had been temporarily absent (**TA**) from Darcy at Westmead Hospital for close to a fortnight although he continued to have a bed allocated to him in Darcy 1. While he was TA, it appears from OIMS that Ryan had been moved between several different cells.

10.4 On 5 April 2019 Ryan had been administratively allocated a bed in cell 39. Once alerted to the incident between Mr Macguire and Mr R, Mr McKenzie used the cell cards, the muster book and OIMS to work out that cell 39 had two inmates, one of which was Ryan, who were both TA. He spoke to Intake but could not get any details on when Ryan might return.

10.5 Because Mr Macguire's cell card was red, Mr McKenzie was aware that Mr Macguire was on a RIT, however, he didn't give any consideration to the appropriateness of placing someone else in cell 38 because Mr Macguire had *already had a cellmate*. Mr McKenzie swapped Ryan's face down muster card from cell 39 to cell 38. His evidence was that he did so as a *placeholder* arrangement. By this he meant that he had no intention that Ryan would necessarily be physically placed into cell 38, but that he had administratively placed Ryan there to deal with the short-term issue of having to separate Mr Macguire and Mr R.

10.6 Although Mr McKenzie assigned Ryan to cell 38 in OIMS, he did not otherwise assess whether this arrangement was appropriate. The assignment in OIMS did not provide any detail to others explaining why the assignment was made or indicate that it was only intended as a temporary administrative arrangement.

10.7 Mr McKenzie was on Darcy 1 for only a few minutes to manage this situation. When his SCO colleague returned from lunch Mr McKenzie recalls speaking to him briefly to say there was a disagreement in the cell, the two inmates had been separated, and that the Darcy 1 SCO would need to make arrangements for the inmate formerly in cell 39 if they came back from hospital. However, whatever the Darcy 1 SCO understood from Mr McKenzie, that information was not handed over to the SCO on the later shift, Mr Scott Perkins.

10.8 When Ryan returned to the Darcy wing on the afternoon of 8 April 2019, Darcy 1 was staffed by two relatively inexperienced CSNSW officers (in terms of the number of previous shifts they had worked on Darcy 1), working together for the first time, one of whom was rostered to Darcy 2 but had swapped to Darcy 1 at the request of a colleague. They apparently received little direct supervision from the SCO who was, in effect the second-in-charge for the whole centre for most of that shift.

10.9 OIMS showed that Ryan was housed in cell 38 because Mr McKenzie had updated OIMS a few hours earlier. The muster card also showed that Ryan was housed in cell 38. Ryan was on an orange muster card as he required camera observation due to matters relating to his physical health, but there was no reason why Ryan could not be housed in a two out assessment cell.

10.10 The evidence suggests that the CSNSW staff involved in physically placing Ryan in cell 38 thought that someone else must have already checked that this placement was appropriate. The cell itself notionally met Ryan's requirements (it was an assessment cell with a camera), however insufficient thought was given to whether it was appropriate to place Ryan *with* Mr Macguire.

10.11 Ryan moved into cell 38 sometime around 4:30pm. He was the subject of a vicious attack by Mr Macguire commencing at some time around 6:24pm that evening and lasting until about 7:24pm. This attack continued even while CSNSW officers moved inmates around the pod. These officers said they did not see or hear anything amiss.

10.12 At the time CSNSW took the view that camera cells needed to be *continually monitored* by CSNSW staff but there was no dedicated position on each shift specifically tasked to monitor the vision coming in from each camera cell. It is difficult to see how continual monitoring could ever have been provided by CSNSW officers who were otherwise responsible for performing a myriad other duties across any given shift. While Ryan was being assaulted, no one was monitoring the images from the camera in cell 38.

10.13 Ryan was discovered at about 7:24pm when CSNSW officers attended the cell with a Justice Health nurse in order to dispense evening medication. The lights were not on in the cell. When they switched the lights on, they saw Mr Macguire kneeling on his hands and knees with his fists on the ground. There was blood within the cell and Mr Macguire reportedly said *I had to do it, I had to do it, it was for the sacrifice*.

10.14 Ryan was declared deceased by a registered nurse on scene at about 7:30pm that night.

11. Events following Ryan's death

Police investigation

11.1 Police were contacted and attended from Auburn Police at approximately 7:47pm. Police viewed CCTV footage and noted that it clearly depicted the offence. Matthew Macguire was arrested and charged with murder.

Autopsy

11.2 An autopsy conducted by Forensic Pathologist, Dr Bernard L'Ons, on 10 April 2019 found widespread superficial and deep injuries involving Ryan's head, neck, torso and limbs.

11.3 Dr L'Ons recommended that based on the history and autopsy findings, the cause of Ryan's death be recorded as neck compression with blunt force craniofacial trauma.

Criminal proceedings

11.4 On 20 April 2020 Mr Macguire was found unfit to be tried and his matter was referred to the MHRT. He was remanded in custody at the Forensic Hospital, subject to any other order of the MHRT.

11.5 On 8 December 2020 his Honour Justice Fagan in the Supreme Court returned a verdict of not guilty to murder on the grounds of mental illness after a special hearing conducted pursuant to s 19(2) of the *Mental Health (Forensic Provisions) Act 1990*.

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

12.1 I make the following findings in relation to Ryan's death.

Identity

The person who died was Ryan Fennell.

Date

Ryan died on 8 April 2019

Place

Ryan died at the Metropolitan Remand and Reception Centre, Silverwater, NSW, 2128

Cause of death

Ryan died due to the combined effects of neck compression and blunt force craniofacial trauma

Manner of death

Ryan died as a result of an assault inflicted upon him by a known person while he was in the lawful custody of CSNSW.

13. Recommendations pursuant to s82 of the Act

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

14. Close of Inquest

14.1 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 Senior Constable Adriano Leite for the very comprehensive investigation he conducted into the circumstances of Ryan's death.

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

14.3 I close this inquest.

Judge Kasey Pearce

Deputy State Coroner

13 May 2026