



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

**Inquest:** Inquest into the death of CD

**Hearing dates:** 4,5,6,7,8 May 2026

**Date of findings:** 29 May 2026

**Place of findings:** Coroner's Court of New South Wales

**Findings of:** Judge David O'Neil, Deputy State Coroner

**Catchwords:** CORONIAL LAW – death at Silverwater Women's Correctional Centre – mental health issues – cell placement decision

**File number:** 2020/00232908

**Representation:** Jake Harris and Anna Payten as Counsel Assisting the Coroner, instructed by Bronwyn Lorenc of the Crown Solicitor's Office

William de Mars for the Commissioner of Corrective Services NSW instructed by Jillian Walsh of DCJ Legal

Ben Bradley, instructed by Benjamin Ferguson of Hicksons Hunt & Hunt for the Justice Health and Forensic Mental Health Network

Dominic Wilcox, instructed by Dominic Longhurst of Longhurst and Associates for CH

Paul Townsend and Danielle Captain-Webb of Legal Aid NSW for CE

**Findings:**

I make the following findings in relation to the death of CD, pursuant to s 81 of the *Coroners Act 2009* (NSW):

**Identity:**

The person who died was CD

**Date of death:**

CD died between 8:15pm on 8 August 2020 and 7:15am on 9 August 2020

**Place of death:**

CD died at Silverwater Women's Correctional Centre, Silverwater, NSW

**Cause of death:**

CD died due to neck compression with plastic bag asphyxia

**Manner of death:**

CD's death was deliberately self-inflicted

**Recommendations:****To the Commissioner of Corrective Services NSW**

- 1 That the Commissioner for Corrective Services consider introducing a framework to be used by correctional officers for resolving grievances between inmates, including, without limitation, where allegations of bullying and harassment are made, the psychological effects of bullying and the risks associated with public/group airing of grievances.
- 2 That the ongoing review of punishments and discipline in light of the Ombudsman's report presented to Parliament on 21 August 2024, include a consideration of the psychological harm of removing phone use for inmates at risk of psychological harm.

**Non-publication orders:**

Orders pursuant to section 74(1)(b) of the *Coroners Act 2009* prohibiting the publication of certain evidence have been made in this inquest. Orders have also been made pursuant to section 65(4) of the *Coroners Act 2009*. A copy of the orders can be found on the Registry file.

# Judgement

## Introduction

- 1 CD was born at the end of 1978. She died in Silverwater Women's Correctional Centre between late on 8 August 2020 and early on 9 August 2020. She was aged 41.
- 2 On the morning of 9 August 2020, CD was found in her cell hanging from a bunk bed with a purple bedsheet tied around her neck and a plastic bag covering her head. The purple bedsheets had been braided to form a 15 millimetre wide ligature. CD was a remand inmate at the time of her death.

## Inquest

- 3 The inquest was held at the State Coroner's Court at Lidcombe between 4 and 8 May 2026. Evidence and submissions were taken on the first four days, and I provided oral reasons for my findings on 8 May 2026.
- 4 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.
- 5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the *Coroners Act 2009* (NSW) (the Act); namely:
  - the person's identity
  - the date and place death, and
  - the manner and cause of death.
- 6 An inquest was required to be held into CD's death in accordance with sections 23(1)(d) and 27(1)(b) of the *Coroners Act 2009* (NSW) as her death occurred while she was an inmate in a correctional centre.

- 7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

### **Coronial Investigation**

- 8 Prior to holding the inquest, a detailed coronial investigation was undertaken. Investigating Police compiled an initial brief of evidence, and a number of documents were obtained, including a report by a forensic pathologist as to the cause of death. The court also received documentary material which included witness statements, medical records, policies and procedures, and an expert report from Professor Matthew Large, forensic psychiatrist.
- 9 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:
- a. Corrective Services NSW; and
  - b. Justice Health and Forensic Mental Health Network
- 10 All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the six-volume brief of evidence that was tendered at the commencement of the inquest, which became Exhibit 1, and included materials gathered by Detective Senior Constable Rollo, the officer-in-charge of the coronial investigation. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, have been considered in making the findings detailed below.
- 11 Counsel assisting summarised much of the tendered material and oral evidence given at inquest in his comprehensive closing submissions. I regard his summary of the events as accurate and, rely on that summary to set out a chronology and to assist with the factual findings. I have also taken into account the helpful closing submissions made by each of the interested parties.

## **Witnesses**

12 The following witnesses gave oral evidence in the inquest:

- a. Detective Senior Constable Cameron Rollo, the officer-in-charge;
- b. Registered Nurse Tracie McMartin;
- c. Dr Rebecca Graham, Specialist Psychologist Corrective Services NSW;
- d. Melanie Cameron, Manager of Security and former Functional Manager at Silverwater Women's Correctional Centre;
- e. Krista Konemann, current Governor at Silverwater Women's Correctional Centre;
- f. Malcolm Brown, General Manager Statewide Operations Corrective Services NSW;
- g. Dr Callum Smith, a psychiatrist and a former staff specialist at Silverwater Women's Correctional Centre;
- h. Professor Matthew Large, an expert forensic psychiatrist; and;
- i. Associate Professor Andrew Ellis, the New South Wales Clinical Director, Forensic Mental Health, for the Justice Health and Forensic Mental Health Network

## **Issues considered in the Inquest**

13 A list of issues was prepared and circulated to the interested parties before the inquest commenced. These issues guided the coronial investigation and were considered at inquest. The issues examined included:

- (1) Did CD receive reasonable and appropriate care and treatment for her mental health in custody?

- (2) Was the response to CD's allegations of bullying or harassment reasonable and appropriate, and in accordance with Corrective Services NSW policy?
- (3) Why was CD placed in a one-out cell? Was this in accordance with Correctives Services NSW policy?
- (4) Was there any indication that CD was at acute risk of self-harm, in the period immediately prior to her death? Should a mandatory notification have been made?
- (5) How and when did CD access a plastic bag and a ligature? Should CD's access to those items have been restricted?
- (6) Was CD's death intentionally self-inflicted?
- (7) Is it necessary or desirable to make any recommendations in relation to any matter connected with CD's death?

## **Background**

- 14 I draw upon CD's own handwritten material from her writings whilst in custody to set out a short background. CD grew up in a single mum family. She had a good childhood, on her account, because her dad left. She describes herself as outgoing and athletic and happily spent childhood holidays on a tropical island at her grandma and grandad's home. Her grandad was like a father figure to her. His passing saddened her. She felt like a piece of her had gone. A person she describes as her first true love was killed in a car accident. She always had professional jobs and a strong work ethic. She completed a degree in psychology as a mature age student. She travelled extensively and loved travelling.
- 15 She describes herself as unlucky in relation to two difficult adult relationships. The birth of her child was a great positive in her life. CD's life changed dramatically on 1 August 2019 when CB was found deceased and CD was located non-responsive at her home, having self-harmed. CD was taken to emergency and admitted, and shortly thereafter within a few days admitted to a psychiatric ward. There was a further self-harm attempt on 9 August 2019. Upon release from the psychiatric ward CD was

released into police custody and charged with a serious offence relating to the death of CB.

- 16 She was bail refused and entered Bathurst Correctional Centre on 15 August 2019 and was subsequently transferred to Silverwater Women's Correctional Centre on 22 August 2019. CD was initially placed in a Mental Health Screening Unit (MHSU), and on 7 September 2019 she was discharged from that unit. A Health Problem Notification Form, referred to as a HPNF, completed that day noted that it was CD's first time in custody and that she had a history of self-harm and ongoing mental health issues. It was also noted that CD was being discharged from MHSU to Willett East as per psychiatrist. The Justice Health placement recommendation was one out cell placement.
- 17 Two days later, on 9 September 2019, a different nurse completed a Health Problem Notification Form which had identical input, apart from the cell placement recommendation. In that HPNF, the cell placement recommendation changed from one out cell placement to normal cell placement. It was accepted in evidence that normal cell placement allowed for one out cell placement, two out placement, or group placement, which, on the evidence, if it occurred, would be four inmates in the cell.
- 18 The nurse who completed that form provided a statement in which she indicated that she had no independent recollection of CD or of updating the HPNF on 9 September 2019. Her usual practice was to review a patient face to face to determine their cell placement needs before updating their HPNF. She noted that in recommending normal cell placement she would have concluded that CD did not have health related concerns and did not present a risk of harm to herself or to or from others, such that another cell placement recommendation was required.
- 19 The nurse further noted that her usual practice was to record her review of a patient on the patient's clinical record, and she could not explain or did not know why she did not make a clinical entry on the occasion of 9 September 2019. She indicated she could only attribute that omission to an oversight in an otherwise busy work environment. Willett East wing was an area which housed Special Management Area Placement inmates, referred to as SMAP inmates. These inmates were separated from the general correctional centre population.

20 As Mr Brown explained in evidence, around the time of CD's incarceration Corrective Services had moved away from non-association and limited association placement for inmates who needed to be away from the general prison population. The only options available were SMAP or segregation. It was in that context that CD entered a SMAP wing.

### **Relevant Events During CD's Time in Custody**

21 On 2 September 2019, psychologist Poppy Rourke approached CD, together with a provisional psychologist. Ms Rourke discussed the conditions of psychology, contact, and review and CD indicated she was unsure if she wanted to have psychology contact. She further indicated she wanted to think about it before formal informed consent was provided. In her notes Ms Rourke summarised the contact as her explaining to CD what was involved in services provided by Corrective Services NSW Psychology and noted that CD had been referred through her name being placed on the relevant system.

22 CD reported she had taken a break from seeing a psychologist she had seen in the community, albeit she had got a lot out of that treatment. CD mentioned she was partly reluctant to engage in psychology contact due to her current charge, ongoing court, and knowing that things she discusses with psychologists can be subpoenaed. Ms Rourke's plan was to follow up in approximately one to two weeks to see if CD wished to engage in psychology contact.

23 On 17 September 2019, Ms Graham, psychologist, requested to see CD for an unscheduled psychology appointment and was informed by staff that CD refused to attend the appointment. On 10 October 2019 Ms Graham made another attempt to engage with CD by placing her on the list to be seen at the Justice Health Clinic. On that day CD was called to the Justice Health Clinic, for the listed appointment, by a Corrective Services NSW staff member. CD refused to go. On 17 October 2019, Ms Graham saw CD in the clinic whilst she was presenting for a medical appointment. Ms Graham again attempted to engage CD to discuss whether she had in fact refused to attend upon a psychologist, and if so her reasons for refusal.

24 Ms Graham's recollection was that CD was concerned about the limits of confidentiality when speaking to a Department of Communities and Justice psychologist, given her upcoming court matters. Appropriately Ms Graham discussed how to refer to

psychology again if CD changed her mind, and CD indicated she understood. As a result of the refusal on 17 October 2019, being a third refusal, CD 's psychology file with Corrective Services NSW was closed. On 23 October 2019, a correctional officer, concerned that CD appeared to be struggling mentally again, referred her to Corrective Services NSW psychology.

- 25 Rather than simply closing the referral and noting that the offender declined service, Ms Graham decided to initiate contact, on 25 October 2019, with the referrer to obtain more information about the nature of the referral. The referrer had concerns about CD's mood but did not think there was any imminent risk concerns. It was confirmed that CD had not herself requested to be seen. A decision was made to refer CD to the Justice Health Mental Health Team to review her mental health, with the recommendation that CD be referred again to psychology if Justice Health Mental Health deemed it appropriate, and CD consented to the referral.
- 26 Corrective Services NSW psychology had acted at all times appropriately through Ms Graham and others involved with CD, and in compliance with policy. They made appropriate attempts to engage with CD.
- 27 On 31 October 2019 a noose was either handed to correctional staff or found by correctional staff in CD's cell. Arrangements followed for CD to see a Justice Health psychiatrist, via Corrective Services appropriately, in accordance with policy, escalating the matter. CD was seen by Dr Callum Smith, psychiatrist, that same day.
- 28 CD subsequently was seen by Dr Smith on 8 November 2019, 7 February 2020, and 5 June 2020.
- 29 On 31 October 2019 Dr Smith reviewed CD's medical file and reviewed her in person. The doctor noted that CD remained at an elevated risk of self-harm and assessed that she would be at chronically elevated risk in that regard. In Dr Smith's opinion, CD had complex trauma, Cluster B personality disorder, and attachment problems. He increased CD's medication, sertraline, in order to see if a higher dose would achieve a greater therapeutic effect in addressing her anxiety and mood symptoms.
- 30 On inquiry regarding the noose, Dr Smith was told that CD's cellmate had presented the noose to the correctional officers in the wing. It was unclear to Dr Smith whether the noose was in fact CD's. He noted it was possible, for example, that the noose was

presented to DCS staff by CD's cellmate in an attempt to have CD removed from the cell that they were sharing. In considering CD's risk of self-harm on that occasion, Dr Smith noted that CD denied thoughts of self-harm and suicide and exhibited forward planning. He reaffirmed nevertheless that she was at chronically elevated risk of suicide.

31 Dr Smith spoke with the Corrective Services officers and then placed CD on what is referred to as RIT. It is an actual referral to a Risk Intervention Team.

32 During the 8 November 2019 consultation, which Dr Smith described as a follow up to his previous review of CD, he again discussed the noose found in the cell. CD denied that the noose was hers. She said that another inmate put it there, indicating they were just "shit stirrers".

33 Upon assessment of CD's risk factors associated with self-harm and suicide, CD reported carrying out previous deliberate self-harm. CD also reported that her father had committed suicide, although this appeared to have been carried out in the context of a diagnosis of terminal cancer rather than due to a mental illness. On that occasion CD did not present with any symptoms of major mental illness, such as major depressive disorder, or any form of psychosis. Dr Smith's opinion that CD had a chronically elevated suicide risk did not change. In this note doctor recorded the importance of non-modifiable factors in terms of risk, which included her charge, her complex trauma and her incarceration.

34 Dr Smith concluded that CD appeared to be of normal mood and that it was unlikely the noose found on 31 October 2019 was hers, whilst acknowledging the possibility that it was. CD reported some symptoms of trauma, including poor sleep and preoccupation. The sertraline dosage was again increased, and 50 milligrams of quetiapine was also prescribed for nighttime administration. On 7 February 2020, Dr Smith found CD to present as bright and reactive, and reported that she had discussed with a Corrective Services NSW psychologist how the prison environment was making her post-traumatic stress disorder worse. I am not sure that there is any record of such a conversation.

35 CD also reported on that occasion that she felt she was doing better on her increased dose of sertraline and quetiapine. She continued to report hypervigilance and a level of paranoia but denied psychotic symptoms. On 5 June 2020 Dr Smith's assessment

- of CD was carried out within COVID-19 restrictions which impacted the prison environment significantly. Dr Smith recorded that CD had upcoming court dates for her serious charge and made some further notes in relation to the events surrounding that charge.
- 36 CD reported she was waking up with nightmares and felt an increase in agitation. CD's medication continued, although there was a change to chlorpromazine. Dr Smith arranged for CD to be referred to outreach, (Justice Health mental health services) and suggested if medical review were needed it best be done by Dr Dorney who had seen CD previously during August of 2019. As indicated, that was the last occasion on which Dr Smith saw CD.
- 37 Returning to 31 October 2019, after Dr Smith referred CD to the Risk Intervention Team she was observed overnight pursuant to an immediate support plan. By the next day CD was discharged with no further action by the Risk Intervention Team. A new Health Problem Notification Form was created which recommended normal cell placement. The signs and symptoms to look for; *first time in custody, history of self-harm, overdose, history of mental health issues, low mood, suicidal ideation*, were not changed in any way. And in terms of recommendation the notation was "*Cleared from RIT to Willett West, normal cell placement.*" That HPNF was completed on 1 November 2019.
- 38 During a search of CD's cell on 27 December 2019 gaol-made alcohol and a sharpened toothbrush which could be used as a shiv were located. CD was confined to her cell for seven days. On 5 January 2020 a further cell search resulted in gaol made alcohol being found buried in containers near CD's outside balcony. No misconduct charges proceeded on the basis it would be difficult to establish ownership.
- 39 On 17 March 2020 the Functional Manager spoke with CD regarding issues she had with another inmate overnight. It had been reported to the Functional Manager that the two inmates were yelling abuse at each other and as a result they were locked in until seen by the Functional Manager. The Functional Manager noted in the case note report that she explained to both, that as it was a small unit they needed to stay away or remove themselves from any conflict. The Functional Manager, Ms Cameron, who gave evidence then went on to note that *CD is a serial antagonist who then plays the innocent victim when she is called on her actions.*

40 It is not recorded in the case note, but the other inmate was moved out of CD's cell. That is recorded elsewhere. In her statement, Functional Manager Cameron indicated at this time the Willett Unit housed a lot of vulnerable inmates, and it appeared to her that CD took pleasure in upsetting the calmness of the unit.

41 Either on 17 March 2020, or shortly thereafter, Functional Manager Cameron gathered all the women together in the common room to have a unit discussion to air any of the issues in the unit. This was an open forum.

42 Ms Cameron's evidence was that a lot of complaints were made about CD in the open forum. These complaints related to CD being nasty and spiteful. Ms Cameron noted CD denied these allegations. Correctional Officer Jess in a statement of hers in relation to having a talk to CD and another inmate in January 2020, about getting on (well) together noted:

*It was a regular occurrence for discussions of that manner to take place with the SMAP inmates, because SMAP inmates lived in each other's pockets. And there were very little work opportunities and few to no programs for them to complete.*

43 Correctional Officer Wheeler noted "*The wing at times could be quite volatile with inmate on inmate, and groups of inmates against others with bullying behaviour.*" In my view those two accounts are somewhat balanced in setting out the reasons why there were issues in the Willett wing, or wings, and the fact that there were occasions of inmate on inmate and groups of inmates against other groups.

44 On 30 June 2020, or about that time, CD wrote a letter addressed to the Functional Manager responsible for the wing in which she was housed. On the evidence Ms Cameron had moved to another position at that time and was not in the Functional Manager as at the end of June 2020. It seems from the content of CD's letter that it was not completed prior to 4 July 2020. It is an eight page letter and refers to events between the date at its start, 30 June 2020, and 4 July 2020.

45 Corrective Services NSW did not find the letter or a copy of it, or a record of its receipt in their documents relating to CD. It is unclear whether it was ever forwarded to Corrective Services NSW. The correspondence contains complaint about other inmates and conduct towards CD, referencing in particular CD's charge. CD lists a

number of inmates who she says witnessed verbal abuse of her and indicates each of those inmates had given her informed consent to list their full names.

- 46 In the letter CD set out that she deliberately got locked in at 2.30pm to entirely avoid the bedlam and then refers to a particular inmate being quite obsessive about her. In other parts of the letter CD complained that she had been told by numerous CSI officers to get over it. That seems to be a reference to Corrective Services Industry officers. Her complaint included that CSI officers were not taking an appropriate approach to a particular inmate and that inmates' actions towards CD, which included continual verbal abuse, were a serious form of psychological harm.
- 47 She again referred to CSI officers indicating, "*I should get over it.*" She asserted the other individual engaged in extensive verbal abuse, psychological manipulation and abuse, defamation of character and stealing from CSI. CD further indicated that she had a tendency to spend most of her time in her cell when not working or gardening, due to the sheer idiocy and gossiping females.
- 48 CD then set out that she put her hand up to making homebrew, something she did often in her 20's as a hobby. She noted it is contraband in CSI, however, it is not illegal in the Commonwealth of Australia. CD further asserted that bullying was rewarded, and *those inmates go out into the community and commit crime*. She further asserted CSI officers allowed inmates to be abusive and violent towards her.
- 49 The point was made in submissions that the references to CSI, are not to be taken to be necessarily drawing a clear distinction between officers involved in the wing as distinct to officers involved in the industry section.
- 50 It was common ground that if the letter had been received by a Corrective Services employee it should have been acted upon by, in the first instance the Functional Manager having a discussion with CD. As I have observed it is not known whether it was ever provided to any correctional officer. The import of the content is that it confirms CD's perception of being bullied and her dissatisfaction with how, at least CSI officers and perhaps other officers, handled the treatment given to her.
- 51 On 2 July 2020 further gaol-brew was found in CD's cell and she was confined to her cell for seven days from 4 to 10 July. On 13 July CD appeared before court by AVL and following a report that she was planning to attack another inmate with a weapon

there was a further search of her cell. The search did not reveal a weapon, but did reveal more gaol made alcohol and a piece of torn linen plaited into a rope with wires from headsets wrapped around it.

- 52 On 17 July 2020, whilst still in segregation, CD completed a Patient Self-Referral Form raising issue as to her mental health if returned to a four out cell. The timing correlation between the Patient Self-Referral Form of 17 July and a letter to the Ombudsman received by the Ombudsman on 22 July is of interest. CD was an intelligent woman who was well-capable of drawing detailed correspondence. The letter to the Ombudsman was not in evidence in the inquest, but the response dated 28 July 2020 says a number of relevant things.
- 53 The response sets out firstly that the letter was received by the Ombudsman on 22 July 2020. Secondly, it noted a complaint about ongoing issues with other inmates at Silverwater Women's Correctional Centre. Thirdly, there was a complaint about issues with CD's placement and her requiring a medical one out cell. Fourthly, it was noted that the Ombudsman made inquiries with the Governor of Silverwater Women's Correctional Centre for information about CD's complaint concerning her safety and about the charges against her for production of alcohol. The Ombudsman also noted that the decision to segregate for a short period was reviewed. Fifthly, it was noted that "*The Governor is aware of your concerns about your safety and advised me, (the Ombudsman) an area manager was going to speak to you.*" It is not known precisely when the Ombudsman, or the Ombudsman's representatives, spoke to the Governor. Sixthly, the Ombudsman indicated he could find no indication of unreasonable or unlawful conduct on the part of Corrective Services NSW or any systemic issue requiring further investigation by the Ombudsman's office in the matters CD had written about, and the file was to be closed.
- 54 In relation to the medical one out cell issue, and the self-referral form, it is not known if and why CD feared that she may be returned to a four person cell, given her indication she had been doing well with a cellmate in cell 18.
- 55 On 22 July CD was released early from segregation for good behaviour. On 23 July she saw Nurse McMartin. Having been attended upon by Justice Health nurses on 15, 18 and 22 July whilst in segregation she was seen by Registered Nurse McMartin, a mental health nurse, in the clinic on the day following her release.

- 56 The evidence is that CD was on the mental health outreach list. CD's self-referral form of 17 July had been received by Justice Health on 20 July and bore a note "*Patient placed on mental health wait list for review and copy of letter.*" Registered Nurse McMartin noticed the wait list entry and noticed CD in the clinic and thus spoke to her. There were, however, two unfortunate errors preceding Nurse McMartin attending upon CD.
- 57 The first was likely a human error, in that the individual who made the wait list entry failed to note SR or S/R on the entry indicating self-referral. The second was a system error, in that the self-referral form was not available to Registered Nurse McMartin. Likely the first error contributed to the second. As at 23 July 2020 the self-referral form could have been in one of three places. Since CD's death the system has been refined so that self-referral forms are in one location.
- 58 The result was the discussion between Nurse McMartin and CD was less focused than it should have been. The response of Nurse McMartin, without the aside of the self-referral form, was to advise CD that cell placement is ultimately an issue for Corrective Services NSW. Nurse McMartin did not have the benefit of the content of the self-referral form, which included, "*I have been in cell 18 for seven months. I still have night-terrors. I cannot return to a four-out, would be at psychological risk of harm.*" There was also a reference to wanting to see a mental health nurse due to bullying and harassment, which had resulted in CD being placed in segregation.
- 59 Through no fault of Registered Nurse McMartin's, this was a missed opportunity for a more detailed discussion about CD's concern about both the bullying and her psychological health. Nurse McMartin indicated in her evidence that had those matters been brought to her attention, not only could she have discussed them with CD, but she would have escalated the issue to the Functional Manager. Coincidentally, it turned out that CD was spoken to by the Acting Functional Manager on 24 July 2020. But this had no relationship to the content of the self-referral form. This was likely in response to a conversation between the Ombudsman's representative and the Governor. I shall return to that conversation later. Despite the errors and the missed opportunity, the fact was that CD was not placed in a four-out cell on her return from segregation.
- 60 On the evidence, the conversation that Nurse McMartin had with CD took place no later than 8.49am on 23 July 2020. That same day - the day after CD's released from

segregation, which had been imposed on 13 July - CD faced the four charges relating to the search on 13 July. The charges were:

- (1) Not follow the rules set out in the inmate guidelines regarding centre routine. On the available evidence, it is not clear what the particulars were of that charge. And in the hearing notes, CD notes or indicates that she hadn't been advised of the guidelines;
- (2) Damage Correctional Centre property. That charge related to the linen;
- (3) Place ingredients together to prepare and manufacture alcohol in a Correctional Centre; and,
- (4) Possess items/goods that are prohibited within a correctional centre.

61 Those last two charges both related to alcohol. There's a troubling similarity in relation to those charges, as they would, and in fact do, on the evidence, relate to the same discovered alcohol. The respective penalties imposed upon the charges being found to be established were:

*Compensation of \$22.00  
Off buy-ups for 64 days  
Off visits for 64 days  
Off phone calls for 64 days*

62 The period of being off buy-ups, visits and phone calls was to commence in each case on 25 July 2020.

63 Returning to the conversation with the Acting Functional Manager on 24 July. I note that occurred in the presence of two other officers, and it related to, as the wording of the case note went, *CD's placement in the wing*. The case notes record, "*CD said she had no issues with anyone in the wing and did not fear for her safety in any way.*" This representation was inconsistent with the self-referral form, the 30 June correspondence, and CD's complaint to the Ombudsman.

64 The Acting Functional Manager who spoke with CD on 24 July had been the delegate who conducted the charge hearing on 23 July. It is unclear on the state of the documentation exactly when the penalty to be imposed was conveyed to CD. Whether CD was awaiting the penalty or knew it as at 24 July 2020, it is understandable she may not have been disposed to confide in the Acting Functional Manager on that day. In a phone call to her mother that day, she indicated that she was still arguing the point with the gaol about her charges. I shall further discuss the process leading to those penalties below. On 25 July, CD wrote to the prison authorities including the following:

*I have ongoing court proceedings running in Queensland. I am ineligible for legal assistance. And my mother, my power of attorney, is providing assistance. I have been taken off phones for 2.5 months. Can you please provide an avenue/response regarding how I am to proceed? Please provide in writing. I understand SAPO cannot assist. Attached Legal Aide letters.*

65 The determination in relation to that request was made on 27 July by the Acting Functional Manager who had imposed the penalties which commenced on 25 July. On 31 July 2020, CD was placed in COVID isolation. The first of August was the anniversary of CB's death and CD's own suicide attempt. At that stage, CD had been confined to cells from 4 to 10 July, in segregation from 13 to 22 July, knew of her punishment, which commenced on 25 July, and she had now gone into isolation. On 2 August 2020, she wrote in her journal: "*Truth is, I wish I would get COVID so I can die, but in reality, I won't die. I have tried to die so many times. Surely this time I will get it right. I'm now running on the red light empty. It's time to go.*"

66 During her time in COVID isolation, CD was attended upon by nurses every day. On 7 August, CD was cleared from isolation. The attendance by the Justice Health nurses during her isolation was for the primary purpose of testing for indicators of COVID, including taking CD's temperature. During that period, the health problem notification form indicated *normal cell placement*. Normal cell placement, as previously indicated, allowed for one out placement, which was the approach for COVID isolation inmates, unless other factors applied. When CD was to be released from isolation, the relevant form was completed. On that day, the nurse who attended upon CD completed answers to these questions:

*How are you feeling on a scale of one to ten.*

*Comment: Five. Wants to move to wing.*

*Do you have any thoughts of suicide or self-harm?*

*Nil.*

*Can you guarantee your safety?*

*Yes.*

*Can you guarantee the safety of others?*

*Yes.*

- 67 It is a consistent theme through the materials that CD would record in writing very serious concerns about what was happening to her and in relation to her own feelings and thoughts, including her thoughts of suicide. However, there is little evidence of these thoughts being relayed to either correctional officers or Justice Health employees. The new HPNF for CD's removal from isolation continued the consistent recommendation of normal cell placement, which allowed for one-out, two-out or group cell placement. CD returned to Willett East and was placed in cell 19. She returned to the wing in the afternoon or early evening of 8 August 2020.
- 68 Correctional Officer Wheeler reported, "*I was going to place CD into a cell with another inmate. However, approximately 30 minutes after the move, the other inmate made threats to self-harm and to harm her cell mate.*" Correctional Officer Wheeler completed the appropriate paperwork and moved the other inmate. This meant CD was in a cell by herself. The cell had two beds in bunk formation. CD had consistently requested and been granted - so far as the evidence revealed - accommodation on the bottom bunk due to Scheuermann's disease.
- 69 Correctional Officer Wheeler confirmed CD could remain one-out pursuant to the recommended normal cell placement. As at 7 August and into 8 August 2020, that was the situation. Correctional Officer Wheeler further reports that at 11am on 8 August, CD approached him and gave him an Inmate Request Form requesting an appeal of an in-custody offence sentence. Correctional Officer Wheeler registered the request

in the Corrective Services New South Wales system, whereupon CD returned to her cell with no issues.

- 70 At 2.15pm on 8 August 2020, CD asked to go into her cell prior to lock in. Correctional Officer Wheeler spoke with CD and asked if she was doing okay. He recorded that he did this, as I previously set out, because the wing, at times could be quite volatile, with inmate on inmate, or groups of inmates against others, with bullying behaviour. Correctional Officer Wheeler wanted to ascertain if CD was coping with the wing environment. His account is that CD stated that she was doing okay and she was ignoring the behaviour of others. She said, "*It is just bullying behaviour,*" and that is why she was asking to be placed into her cell. She thanked Correctional Officer Wheeler for asking. She did not show any signs of suicidal ideation or that she was not coping. Correctional Officer Wheeler noted that being asked by inmates to be secured into their cells at 2.30pm rather than stay out for the hour before 3.30pm was not an unusual occurrence.
- 71 At 8.15pm, a registered nurse was escorted to CD's cell to provide CD with her night medication. On the evidence, CD accepted the medication without issue. On 9 August 2020, CD did not respond when Correctional Officer Wheeler, who was back on shift, attended her cell as part of the morning head count. Correctional officers entered the cell and found CD hanging, as previously described. CD was motionless and unresponsive. The noose was cut and a call was made for medical assistance. CD was found by the medical team to be unresponsive, cold to touch, and there were signs of rigor mortis.
- 72 In her journal - found after she had passed - the following entry headed "8/8/20" appears, "*Hello. The relentless bullying here in Silverwater has seriously impacted my mental health, it has become too much. Please organise a courier of the one*" - she then goes on to describe the container and a bag and ask that they be sent to her mother, then records: "*This is my final request. Thank you. [CD]*"
- 73 Amongst her notes, there was also recorded: "*Here's to my amazing mum. 100% unconditional love. Couldn't ask for a better human to have walked with in this life, and I'll see her again.*" In another portion of the notes: "*Set in stone, my only hope lies in this rope to give me back a time without pain, without sorrow.*"

- 74 CD died between 8:15pm on 8 August 2020 and 7.15am on 9 August 2020 at Silverwater Women's Correctional Centre, Silverwater, New South Wales. The cause of CD's death was neck compression with plastic bag asphyxia. CD's death was deliberately self-inflicted.

## **Discussion of Issues – Findings**

- 75 I now address the issues as set out on the issues list referred to earlier in these findings.

### **Issue One: did CD receive reasonable and appropriate care and treatment for her mental health in custody?**

- 76 There was no dispute between Professor Large and Doctors Ellis and Smith as to CD's diagnosis of complex trauma with features of cluster B personality disorder and post-traumatic stress disorder. Some of the features included poor distress tolerance, substance abuse (specifically alcohol), impulsivity and poor relationship maintenance. CD also suffered major depression.
- 77 As initially set out by Dr Smith, CD remained at a chronically elevated risk of self-harm and suicide throughout her time in custody. In terms of assessing the risk of suicide, as previously referred to in Dr Smith's notes, there were non-modifiable risk factors and modifiable risk factors. The non-modifiable risk factors included CD's trauma history, previous acts of self-harm, the serious charge CD was facing, and the fact of incarceration. The modifiable risk factors included distress, anxiety and mental illness/disorder.
- 78 The evidence was clear that CD required both psychiatric and psychological treatment if she was to improve her mental health to any significant degree. As set out above, CD elected not to engage with psychological treatment offered by Corrective Services New South Wales. Dr Smith was not asked to comment, understandably, on issue one. Professor Large and Dr Ellis were of the view that the care and treatment of CD was reasonable and appropriate. I accept that view. Dr Large did comment that the 31 October 2019 noose incident should have been further followed up whilst noting the time gap between it and CD's death, suggesting that follow up closer to 31 October 2019 likely would not have changed the course of events. Specifically in relation to

that issue, Dr Ellis was of the view that given all the circumstances of the custodial setting, Dr Smith's approach was reasonable.

- 79 In accepting the experts' view, I note Dr Ellis provided his statement at the request of Justice Health. Nevertheless, he is clearly an expert in this area and gave evidence together with Professor Large. In accepting their joint view, I cannot leave the area without consideration of events in July of 2020. As I have observed above, CD, had to deal with a great deal in that month and early August. She was locked in her cell, in segregation or in isolation for 25 days between 4 July and 8 August 2020. On four of those days, the period of segregation or isolation removal may have been less than a full day due to exiting and entering the various forms of removal.
- 80 CD being locked in cell by herself for seven days upon the 2 July discovery of alcohol was in keeping with other penalties for that breach observed in the evidence and, in that context, seemingly appropriate. The course of events following the 13 July cell search cannot be so categorised. In my view, the description of the rope discovered that day is so strikingly similar to the description of the "noose" from 31 October that I am satisfied those who found the rope should have elevated the issue so that it came to the attention of Justice Health.
- 81 To be clear, whether those involved knew anything about 31 October or not, it's the description that should have caused a reaction. The 31 October description is this: *a working noose was found while searching cells, which was made from torn strips of bedding sheet plaited to make it strong.* The 13 July 2020 descriptions are: *"torn linen that had been plaited into a rope with wire wrapped around it; torn sheet that had been platted into a rope with wire twisted around it; gaol linen had tied cable and wires from headsets from Gencore around the linen and had made rope out of it."*
- 82 Despite the records indicating that a photograph was taken of the rope, Corrective Services New South Wales have been unable to produce any clear photograph of what was discovered on that occasion.
- 83 Attention was drawn in submissions to another inmate who had been a cell mate of CD referring to the linen rope as being made into a "tea-cosy". In my view, the reference to a "tea cosy" was what might have been suggested the rope was (upon discovery), to distract attention from any other purpose.

84 I'm satisfied that rather than a purely punitive approach, at least one consideration should have been that the rope could be used for self-harm and Justice Health engaged. It's uncontroversial that Corrective officers have responsibilities in informing Justice Health of relevant health issues, particularly in relation to suspected self-harm. So much is clear from COPP - Custodial Operations Policy and Procedure - 3.7 *Management of inmates at risk of self-harm or suicide*, and the requirement to complete a HPNF so as to direct attention to signs and symptoms that Corrective Officers are to look for in the inmate. It's already been observed that the Health Problem Notification Forms in relation to CD, regularly, if not always, contained the following wording "*First time in custody, history of self-harm, overdose, history of mental health issues, low mood, suicidal ideation*."

85 It appears to me, on the basis of the records, in particular some Immediate Action Team (IAT) officers referring only to the discovery of the alcohol and the removal of CD, that CD was taken into segregation very shortly after the search commenced, whilst other officers found the rope thereafter. Whether that's what occurred or not, the fact is, the only action taken was punitive. The 13 July discovery was never brought to the attention of Justice Health. This was a missed opportunity.

86 As I've also observed, the day after release from that segregation, CD faced the hearing in relation to what was found in the search. Custodial Operations Policy and Procedure 14.1 deals with inmate discipline. As at the time, the following applied: "*The Governor or delegated officer may impose one (but not more than one) of the following penalties.*" Included in the list of penalties: "*deprivation for up to 56 days of such withdrawable privileges as the Governor may determine, confinement to a cell for up to seven days, with or without deprivation of withdrawable privileges.*"

87 At 4.3: "*Considerations before withdrawing privileges*" is the header. That section includes, "*Contact with family and friends is an integral and effective management tool. An inmate's contact visit and telephone privileges should only be withdrawn as a last resort.*" Mr Brown confirmed that to be the position specifically in relation to CD's case. It was a privilege which was to be withdrawn only as a last resort.

88 The Ombudsman of New South Wales conducted an investigation into inmate discipline in New South Wales correctional centres, which resulted in a report provided by the Honourable Benjamin Franklin, the President of the Legislative Council to the Parliament on 21 August 2024.

89 Throughout his helpful, informative and concise submissions, Mr De Mars acknowledged the Commissioner has (and did so in 2024 as I understand it), delivered a positive response to the content of this report, which is available on public record. Items of interest in that report in relation to CD's case, are these:

*Our overarching conclusion is that there is a systemic failure to follow the requirements of the legislation and the relevant policies in relation to inmate discipline. In some cases, this is leading to unjust outcomes and potentially unlawful decisions. We saw maladministration at all steps in the disciplinary process which was not confined to any particular centres or decisionmakers.*

*Key observations and conclusions. "In relation to the conduct of inquiries and the making of findings of guilt" –*

*It appears that in the last ten years, no consideration has been given to the referral of any Correctional Centre offence for hearing by a visiting magistrate, as is permitted by the legislation. Inmates whose behaviour would more appropriately warrant referral for mental health support, for example, behaviour that is primarily self-harming in nature are being dealt with through the disciplinary process. Insufficient regard is being paid to the requirement that withdrawal of phone calls and contact visits is to be a penalty of last resort, and some inmates have been subject to impermissible penalties, including multiple penalties for the same offences and penalties, such as self-confinement and withdrawal of privileges that exceed the maximum duration of penalties under the Act.*

90 The person who conducted the hearing of the July charges was not called to give evidence during the inquest. For clarity, I repeat, it was not Ms Cameron; she was not at the centre from June 2020. On their face, the penalties were in part excessive at law and likely had an adverse impact upon CD. Professor Large described the penalty of withdrawing the phone privileges as draconian. I've already drawn attention to the disturbing similarity between the third and fourth charges as I set them out; they both seem to relate to the one substance, alcohol. Additionally, on its face, imposing a penalty of 64 days when the maximum available was 56 days, seems to exceed the penalty power.

91 There may be factors not traversed in this inquest in relation to the penalties that are of significant relevance. But as I have said, on their face, they seem to me, severe, and in part outside power. In saying both those things, I note that there's no clear reason provided in the documentation why the fact that CD had already been in segregation up until 22 July, following the cell search on 13 July, should not itself be considered as a form of punishment.

92 Whatever other factors may have fed into the determination of penalty, it is undoubted that the penalties had a very significant impact on CD. I've made particular mention, as did Professor Large, of withdrawal of the phone usage. That is because, on the evidence, CD's mother was not someone who visited her in person, but phone contact with her mother was an extremely important factor in CD being able to cope, to the extent she did, with her incarceration. Professor Large in his written report said,

*It is likely that CD's loss of access to the telephone, and the attendant loss of her only social support in the form of contact with her mother, left her feeling more isolated and hopeless. Isolation and hopelessness are well known suicide risk factors.*

93 Another matter to consider in the context of the care provided is CD's refusal to engage with the departmental psychologist. Shortly before the inquest commenced, the statement from Dr Ellis was provided to the assisting team.

94 In that statement, Dr Ellis raised the issue of the psychologists in New South Wales custodial settings having the same employer as Corrective Services officers; as I've set out in the evidence in this inquest, universally referred to as Corrective Services New South Wales psychologists.

95 These psychologists are in the position of performing dual roles. On the one hand, Corrective Services New South Wales business, for want of a better term; and on the other the provision of therapeutic services. New South Wales Corrective Services - business, as I have used the term - might include, conducting programs - although mostly this would occur with sentenced inmates and reports for parole and high risk offender applications, for example. There is a view that it is an impediment to access to therapeutic services that the psychologists are asked to perform this dual role. The issue was dealt with in some detail in the inquest into the death of Matthew Lothian. The State Coroner made the following recommendation:

*Justice Health New South Wales and Corrective Services New South Wales consider the benefits of therapeutic psychological services being provided by Justice Health New South Wales, including how such services would be funded.*

96 Justice Health New South Wales responded that it *"supports the recommendation and will work in partnership with Corrective Services New South Wales to explore options on how best to ensure inmates with health needs have access to psychological services."*

97 The formal response from Corrective Services New South Wales was as follows"

*Corrective Services New South Wales notes the recommendation to expand psychological services through Justice Health. Corrective Services New South Wales psychologists provide comprehensive therapeutic care tailored to the correctional environment, with continuity between custody and community being critical to rehabilitation and public safety.*

*All psychologists are bound by the same confidentiality standards and refusal to engage with Corrective Services New South Wales psychologist is rare (approximately 0.5%). Corrective Services New South Wales will continue to strengthen its psychological services, including exploring supplementary support where appropriate, ensuring any expansion is properly funded and integrated.*

98 The issue was not fully explored in this inquest. Given when the issue arose (in the proceedings) Corrective Services New South Wales did not provide a reply to Dr Ellis and did not seek to reply to the oral evidence on the understanding that the approach I would take in my findings would be to refer to the evidence on the topic and not make any recommendations.

99 The three psychiatrists who did give evidence support the idea that Justice Health should provide psychological service in New South Wales prisons. Dr Smith suggested the current arrangement is illogical. Dr Ellis said, *"It is a known impediment to some inmates engaging in psychological services."* Professor Large said that all settings in which he has worked adopt multi-disciplinary approaches and expressed

the view that is the best way to get an outcome in the mental health setting. Professor Large has not worked in the custodial setting.

100 Relevant factors include, on the evidence, Corrective Services New South Wales employed psychologists place some information in Corrective Services digital files readable by other Corrective Services New South Wales employees. This requires the consent of an inmate patient, and some patients refuse to engage at that stage. CD was in that category. She did not consent.

101 Psychiatrists' notes in the custodial setting prepared by Justice Health employed psychiatrists are not available to Corrective Services New South Wales psychologists. If psychologists in a custodial setting were employed by Justice Health, the psychiatrists could share the information provided to them with the Justice Health psychologists, with appropriate consent. All notes of Justice Health employed psychiatrists, psychologists, mental health nurses, drug and alcohol counsellors and other clinicians could be shared with appropriate consent. It was suggested that consent could more easily be obtained, when all those service providers are within the Justice Health organisation rather than the services being split between Justice Health and CSNSW.

102 I stress again, Corrective Services New South Wales did not put on evidence to address this issue, and I accept there will be factors not dealt with in this inquest which Corrective Services would seek to raise in relation to the issue. I make no determination on the issue beyond observing it's possible CD's decision to not engage with psychologists employed by Corrective Services New South Wales was connected to that very fact. The expressed reason of CD for not engaging was because the psychologist records could be subpoenaed. The fact is, mental health nurses and psychiatrist's records could also be subpoenaed, and yet CD engaged with them. My view is it's highly likely she knew those records could also be subpoenaed. She herself had studied psychology and had a degree in psychology.

103 Submissions were made by the Commissioner on the issue of why CD didn't engage. The Commissioner pointed to different roles of psychologists and psychiatrists. I note, however, that in August 2019 at Silverwater Women's Correctional Centre, CD engaged with a psychiatrist in the very style of revelation, it was suggested, psychiatrists would not deal with, including the circumstances surrounding CB's death. I've also extracted parts of, or referred to, CD discussing issues around CB's death

with Dr Smith. Ultimately, however, I can't conclude with any certainty why CD did not engage with psychologists in custody, and whether she would have engaged with psychologists if they were employed by Justice Health. The opportunity to revisit the issue is likely to come up in future inquests.

104 To complete issue one, I note Dr Smith's prescription of medication for CD, including the variation of medication, was reasonable and appropriate. Overall, the care and treatment provided to CD was reasonable and appropriate, given what was known to Justice Health from time to time, and CD's decision not to engage with Corrective Services New South Wales psychologists.

**Issue Two - Was the response to CD's allegations of bullying or harassment reasonable and appropriate, and in accordance with Corrective Services NSW policy?**

105 The evidence was that bullying was not uncommon in the custodial setting, and specifically, as already referred to, not uncommon in the Willett wing or wings. Despite that, as Mr Wilcox submitted there is little evidence in relation to the response to CD's allegations. This is because :

- (1) much of what is known of CD's complaints is in written form;
- (2) in relation to the 30 June letter, it's not known whether it was ever received by Corrective Services; and,
- (3) in relation to the letter to the ombudsman, whilst the content was discussed, with the Governor, the full detail of the conversation between the Ombudsman's representative and the Governor is not known.

106 What evidence there is of the allegations being responded to, relates to the "grievance session" on or about 17 March and the interaction on 24 July 2020.

107 As previously set out, on or about 17 March 2020, Ms Cameron called together the inmates from the wing to air their grievances. Both Professor Large and Dr Ellis commented that there were risks with such an approach, and that whilst there might be a net benefit, the person conducting the session would need a level of expertise and need to be careful as to how the session was conducted. On Ms Cameron's account, a number of inmates criticised CD in front of CD in the circumstances. As

best I can assess, this likely did not assist CD. Professor Large and Dr Ellis pointed to the risk of social ostracisation. This is an aspect of isolation. And as Professor Large pointed out, the studies indicate that's a significant risk factor for suicide.

108 In relation to the interaction on 24 July between the Acting Functional Manager and CD, I have already made observations in relation to the circumstances of that interaction. I consider the circumstances unfortunate in terms of the potential to effectively address CD's concerns about bullying and harassment. In my view, it was significantly unlikely that CD would advance her concerns to the Acting Functional Manager in the circumstances that existed.

109 Mr Brown, in his usual forthright and helpful style, indicated that there was no existing framework to guide and direct correctional officers for resolving grievances between inmates, and that such a framework could be helpful. This evidence, which was agreed with by the current Governor of Silverwater Women's Correctional Centre, led to a recommendation being agreed upon between the parties. I will come to that in due course.

110 In my view, Ms Cameron undertook the course she took in good faith, seeking to do the best she could in a difficult situation. She did seem to have an adverse view of some of CD's behaviour, and as I set out previously, other officers might be thought to have had a more benign view of the way CD interacted with the others. Having said that, I think it is only fair to note that CD's diagnosis and aspects of her conduct were likely, at times, to at least contribute to the problem she had with some of her fellow inmates. There is no suggestion the response to CD's allegations was outside Corrective Services policy.

### **Issue Three: Why was CD placed in a one-out cell? Was this in accordance with Corrective Services New South Wales policy?**

111 It is clear on the evidence, which I have set out above, that CD came to be in a cell alone due to happenstance. There was no deliberate determination outside the events that transpired to place her alone in a cell. There's an irony in the fact that CD, on occasions, suggested her preference was to be one-out in a cell, a most tragic irony at that.

- 112 Given Professor Large's view, that the main problem for CD was her circumstances, in that the non-modifiable factors, to use Dr Smith's terminology, were unlikely to change at any time in the foreseeable future. CD, as Professor Large saw it, faced a very bleak future and likely considered suiciding for months. Professor Large was clear that he viewed having a cellmate as a protective factor and a significant protective factor based on empirical evidence. Dr Ellis thought it may not have been as strong a protective factor as Professor Large set out but agreed it was a protective factor and noted that being alone provided an opportunity to undertake the course CD ultimately took, without the risk of immediate discovery.
- 113 In my view, being one-out in the cell was yet another factor in the July/August 2020 period, which added to the risk of CD suiciding. Having said that, her being in a cell one-out was not in breach of any Corrective Services New South Wales policy.
- 114 In helpful submissions, Ms Captain-Webb drew my attention to the fact that the availability of hanging points has been a well-identified issue in the custodial setting for a long time. The detail of the Corrective Services program to remove all hanging points was not explored in this inquest. Counsel assisting brought to my attention a recent consideration of those issues in the Inquest into the death of Phillip Mitchell Boney which proceeded before then Deputy State Coroner Ryan.
- 115 Her Honour heard evidence that funding for the removal of ligature points is determined by NSW Treasury pursuant to a prioritised program which is based upon risk assessment with priority given to correctional centres where inmates are considered to be the most vulnerable to self-harm or suicide.
- 116 Her Honour observed that the Corrective Services NSW policy of removing ligature points in New South Wales prisons had been underway since 2016 and yet in the inquest in relation to Mr Boney's death there was no plan in place to remove the ligature point which Mr Boney had accessed.
- 117 Her Honour made a recommendation to the Acting Commissioner of Corrective Services NSW that immediate steps be taken to remove all hanging points from the John Morony Correctional Centre and to expedite as a matter of urgency the identification and removal of hanging points in correctional centres throughout NSW.

118 Further consideration of the progress made in removing hanging points in correctional centres throughout NSW is apt for further detailed consideration in upcoming inquests in which the issue arises.

**Issue Four: was there any indication CD was at acute risk of self-harm in the period immediately prior to her death? Should a mandatory notification have been made?**

119 One of the reasons I set out the evidence in the detail I did earlier in these findings was to make clear the basis of my findings in relation to this issue.

120 Whilst the risk factors were accumulating during the July/August period the risks were not brought to the attention of Justice Health, or, other than my view in relation to the 13 July 2020 happenings, Corrective Services. In saying that, I do not say that the events on 13 July revealed an acute risk of self-harm but rather revealed a situation that should have been escalated to Justice Health. It's not the responsibility of correctional officers in any sense, to make assessments of the risk of self-harm beyond escalating an identified risk of self-harm to Justice Health. My comments in relation to 13 July must be considered in that context.

121 The issue as structured focuses upon the period immediately prior to CD's death. I've set out above the attendances by Justice Health employees upon CD in her period of COVID isolation, the questions asked of her in relation to self-harm as late as 7 August, and her answers to those questions, and the observations of Correctional Officer Wheeler on 7 and 8 August 2020. Additionally, a nurse saw CD when CD was given her medicine on the night of 8 August. There was no indication to any of those individuals that there was an acute risk of self-harm on those days. Relevant to this issue was the clear evidence of the three psychiatrists that suicide is notoriously unpredictable, including as to when it might occur. It cannot be said that a mandatory notification should have been made in the period immediately prior to CD's death.

122 The final factor to mention in the context of issue four, I've already mentioned above, being that most of CD's revelations as to her feelings and possible intent were written. It seems verbal expressions of self-harm were relayed to a number of inmates, but rarely, if ever, to clinicians or correctional officers. CD and the inmates would not have expected what she said to the inmates to be passed on to correctional officers, and there is no evidence that those comments were passed on in the period leading up to her death. The record of self-harm comments having been made to inmates first

occurred following CD's passing when those inmates were interviewed in the initial Corrective Services investigation.

**Issue Five: How and when did CD access a plastic bag and a ligature? Should CD's access to those items have been restricted?**

123 Mr Brown gave evidence that items like plastic bags are not generally subject to restriction in the prison population. They are commonly used. On occasions they are used to transport possessions between different correctional centres. They provide a hygienic carrying container. They are often clear for considerations of both hygiene and security. Mr Brown's further evidence was that if an inmate is identified to be at risk of harm and is in an assessment cell, for example, such items would be removed or restricted.

124 The availability of the plastic bag, or bags, as the photographs revealed, to CD went hand in hand with the earlier findings that there was no evidence available to any relevant individual of CD being at acute risk of self-harm. The ligature was made out of the bed linen, and there was no suggestion CD should have been denied bed linen. It was common ground that in the circumstances, there could be no criticism of any individual or entity for CD having access to the bag or ligature.

**Issue Six: Was CD's death intentionally self-inflicted?**

125 It is clear from what has already been said that CD's death was intentionally self-inflicted. Supporting that view are the accounts of other inmates post CD's death in relation to what had been conveyed to them about CD 's plans to end her life and join CB. Additionally, there was the note dated 8 August 2020, referred to above, which CD left in her cell, her journal entries, the mechanism of death and the fact no one entered her cell between 8.15pm the night before and when CD was located deceased the next morning.

**Findings section 81 Coroners Act 2009**

126 Having considered all the evidence, the findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

***Identity***

The person who died was CD

***Date of death***

CD died between 8:15pm on 8 August 2020 and 7:15am on 9 August 2020

***Place of death***

CD died at Silverwater Women's Correctional Centre, Silverwater, NSW

***Cause of death***

CD died due to neck compression with plastic bag asphyxia

***Manner of death***

CD's death was deliberately self-inflicted

**Recommendations pursuant to section 82 Coroners Act 2009**

- 127 An agreed position was reached in relation to recommendations. Counsel assisting initially made one recommendation. Mr Wilcox helpfully suggested an addition to that recommendation and two other recommendations. The third suggested recommendation fell away during submissions and an agreed position was reached in relation to recommendations 1 and 2. I thank the Commissioner for his approach to the recommendations being made.
- 128 In relation to Recommendation 1 there was some discussion as to the wording and the final form was left to my discretion.
- 129 Recommendation 2 flows from the evidence of Mr Brown, wherein he indicated the content of the recommendation to be a pathway being travelled by CSNSW at this stage.
- 130 I make the following recommendations to the Commissioner of Corrective Services NSW.

**Recommendation One**

That the Commissioner for Corrective Services consider introducing a framework to be used by correctional officers for resolving grievances between inmates, including, without limitation, where allegations of bullying and harassment are made, the psychological effects of bullying and the risks associated with public/group airing of grievances.

## Recommendation Two

That the ongoing review of punishments and discipline in light of the Ombudsman's report presented to Parliament on 21 August 2024, include a consideration of the psychological harm of removing phone use for inmates at risk of psychological harm.

## Conclusion

- 131 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to CD's family and friends.
- 132 My thanks go to the officer-in-charge Detective Senior Constable Rollo, for his assistance in putting together the Brief of Evidence in the investigation stage of the coronial process.
- 133 I acknowledge and express my gratitude to the assisting team, Mr Harris and Ms Payten of Counsel instructed by Ms Lorenc of the Crown Solicitor's Office.
- 134 In addition, I thank the legal representatives for each of the interested parties for their assistance provided throughout the coronial proceedings.
- 135 I close this inquest.



**Judge David O'Neil**  
**Deputy State Coroner**  
**Coroner's Court of New South Wales**  
**29 May 2026**