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

Inquest: Inquest into the death of PE

Hearing dates: 30 March – 1 April 2026

Date of findings: 1 May 2026

Place of findings: NSW State Coroner's Court, Lidcombe

Findings of: Judge Harriet Grahame, Deputy State Coroner

Catchwords: CORONIAL LAW – Death in custody – Parklea Correctional Centre - self-inflicted death – hanging points in custody – provision of telephone calls in custody

File numbers: 2024/45150

Representation: Ms Peita Ava Jones, Counsel Assisting the Coroner, instructed by Ms Kathleen Campbell (NSW Crown Solicitor's Office)

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Non Publication orders

Non Publication orders were made pursuant to ss 74(1)(b) and 75(1) and (2) on 20 August 2025, 1 April 2026 and 1 May 2026. A copy of those orders is available from the Registry.

Findings

I make the following findings pursuant to section 81(1) of the *Coroners Act 2009* (NSW).

Identity: The person who died was PE

Date of death: He died on 3 February 2024

Place of death: He died at Parklea Correctional Centre, in area 2

Cause of death: He died from hanging.

Manner of death: PE's death was intentionally self-inflicted.

Recommendations:

- 1) *CSNSW is to review COPP 8.2 Inmate Telephones and related phone policies and procedures to consider increasing access to personal telephone calls for unsentenced inmates to either an Australian mobile phone number or landline number (local or national). The review will include consideration of the following initiatives:*
 - a) *Immediate renegotiation of call rates to reduce landline and mobile call charge rates for inmates*
 - b) *A centralised processing model for phone numbers and phone money at large remand centres to expedite the activation of inmates OTS accounts, and*
 - c) *Automatic phone account credit for inmates on reception to ensure calls are automatically available upon entry into custody.*
- 2) *CSNSW is to review their phone policies for inmates in the context of the steady decline of landline usage and ownership in Australia. In particular, the feasibility of offering an increased number of free or reduced rate calls to mobile numbers and landlines to all inmates should be investigated and consideration be given to implementation.*

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Introduction

1. PE was pronounced deceased by a NSW Ambulance paramedic on 3 February 2024 at Parklea Correctional Centre (Parklea) where he was being held in lawful custody. He was 53 years of age.
2. PE had entered custody on 29 January 2024, only four days earlier.
3. PE was described by his family as having a huge heart. His greatest joys came from his connection to the people he loved. His devotion to his wife, daughters and sisters was described as unwavering. In a moving family statement his daughter told the court that he was always ready to help an elderly neighbour or undertake his union duties with compassion and integrity. He valued kindness, laughter and friendship.
4. PE had never been in custody before and his family believe the effect of suddenly being away from those he loved must have disturbed him greatly. This family stated that they miss him every day. I acknowledge their grief and offer them my sincere condolences.

The role of the coroner and the scope of the inquest

5. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.¹ A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.²
6. PE was a remand prisoner at the time of his death. He was suddenly cut off from his supportive family and must have struggled to settle into his new environment in the context of the very serious outstanding charges he faced. The court was informed that PE had never previously voiced thoughts of self-harm or ever attempted suicide. It was thus necessary to examine the way in which his transition to custody was managed to understand whether there are lessons to be learnt which might prevent future tragedies of this kind.
7. PE was held at a privately operated prison. Parklea Correctional Centre (Parklea) is managed and operated by Management & Training Corporation (MTC) pursuant to the terms of a Management Deed with the Commissioner of Corrective Services (CSNSW). Medical care for inmates at the facility is provided by St Vincent's Hospital Sydney Limited (SVH) pursuant to an agreement with MTC. Prisoners housed in privately run prisons are entitled to the same level of care as those housed in facilities directly managed by the State of NSW.

¹ Section 81 *Coroners Act 2009* (NSW).

² Section 82 *Coroners Act 2009* (NSW).

8. It should be noted that when a person dies in custody in NSW, it is mandatory that an inquest is held.³ The inquest must be conducted by a senior coroner.⁴ When a person is detained in NSW, the State is ultimately responsible for his or her safety and medical treatment. Given that inmates who may be experiencing a mental health crisis are unable to obtain medical treatment or support of their choice it is especially important to closely examine the care they are offered so that we can be confident that it is always of an appropriate standard.

The evidence

9. The inquest was held at the NSW Coroners Court at Lidcombe from 30 March to 1 April 2026.
10. A six-volume brief of evidence was tendered, including witness statements, police reports, and photographs, medical and custodial records, reports and policy documents.
11. The court heard from two employees of MTC, Correctional Officer Hulett who conducted the ISQ screening and former Parklea Governor Mr Wayne Taylor. There were also three witnesses from CSNSW. Malcolm Brown, General Manager, Statewide Operations within Security and Custody, Crosbi Knight, Director, Correctional Practice and Renee Van Aaken, Director, Strategic Delivery Unit.
12. The court also had the benefit of an expert report provided by Dr Seidler, who also gave oral evidence. Dr Seidler is a clinical and forensic psychologist and is the Director of LSC Psychology. Dr Seidler holds a PhD in Psychology focusing on interpersonal violence and cultural experience and a Masters in Clinical Psychology. Dr Seidler has previously worked as a Clinical Psychologist for the NSW Department of Corrective Services.
13. Prior to inquest proceedings commencing, a list of issues was circulated to the parties. After setting out a brief chronology of events, I deal with each of these issues in turn. I have been assisted by the comprehensive submissions provided by counsel assisting in this regard.

Background

14. PE was the much-loved husband of LE and father of two daughters. PE and LE met in Bathurst in 1997, married in 2001 and lived in their family home in Busby for 25 years. PE and his wife were close and usually spoke on the telephone 3-4 times a day.
15. PE was also a loving son and brother. He supported the Parramatta Eels and worked in the aluminium can processing field for much of his adult life.

³ Section 27 *Coroners Act* 2009 (NSW).

⁴ Section 24 *Coroners Act* 2009 (NSW).

16. He was described as having a gift for connection and as someone remembered for his personal warmth, humour and energy. At the time of his death PE was facing very serious criminal charges, which had yet to be determined.

Parklea Correctional Centre

17. Before turning to events proximate to PE's death, it is convenient to provide some brief information about Parklea Correctional Centre.
18. Parklea is privately operated by Management and Training Corporation Australia (**MTC Australia**) on behalf of the NSW Commissioner of Corrective Services (**CSNSW**). MTC has operated Parklea since 1 October 2022. Prior to that MTC and Broadspectrum (Australia) Pty Ltd operated Parklea together until the dissolution of their joint venture on 1 October 2022.
19. MTC operates Parklea and conducts the routine maintenance of its infrastructure. However, MTC does not own the infrastructure itself. Any infrastructure upgrades that take place at the Centre must be undertaken or approved by CSNSW.
20. MTC has developed and maintains specific policies and procedures for Parklea which are generally known as Parklea Operating Procedures (**POP**). MTC also follows specific CSNSW policies and procedures known as Custodial Operations Policy and Procedures (**COPP**).
21. Health services at Parklea, including all mental health services, are provided by St Vincent's Correctional Health (**St Vincent's**) under a sub-management agreement with the Justice Health and Forensic Mental Health Network (**Justice Health**).⁵
22. St Vincent's are required to carry out their work at Parklea in alignment with a number of Justice Health policies and their own procedures.
23. On 2 March 2025, the NSW Government announced that Parklea would return to state operation. On 17 March 2025, MTC received formal notification from CSNSW that the operational deed would be extended for six months with Parklea returning to state operation on 1 October 2026. Healthcare at Parklea will be delivered by Justice Health from the same date.
24. The transition of Parklea to CSNSW commenced on 1 October 2025.

⁵ For scope of services see, for example, findings in the *Inquest into the death of SB*, 11 December 2020 at [17] – [19].

Arrest and entry into custody

25. On 29 January 2024, PE was arrested and charged with six child sex offences at Blacktown Police Station. He was bail refused by police and entered Amber Laurel Correctional Centre (**ALCC**). PE had no prior criminal history and this was his first time in custody.
26. The offences involved an allegation of serious sexual conduct against a female relative.
27. A New Inmate Lodgement & Special Instruction Sheet was completed at ALCC which indicated no mental health or self-harm concerns. This was consistent with the NSW Police Force Custody Management Record completed the day prior.
28. On 30 January 2024, PE was refused bail at Blacktown Local Court and transferred to Parklea. Shortly after arrival, inmates at Parklea are (amongst other things) interviewed by the Reception Supervisor. They should be informed that they will get a welfare telephone call during the later Intake Screening Process, when an Inmate Screening Questionnaire (ISQ) is undertaken. During the ISQ they will also be provided with the Inmate Handbook and given information about how to make telephone calls.
29. At 6:15pm on 30 January 2024, the CSNSW form *Reception and Accommodation Checklist* was completed. It records that PE had expressed no current thoughts of self-harm or suicide and that he had no immediate medical requirements.
30. PE received a health screen by St Vincent's registered nurse Mr Paul Cooksley that same evening. This included completion of the Justice Health Reception and Screening Assessment (**RSA**). The RSA is a mandatory process.
31. The RSA is described by Justice Health Director of Nursing – Metropolitan Primary Care, Therese Sheehan, in her statement to the Court as follows:

“The Reception Screening Assessment (RSA) is a comprehensive patient focused health screening tool designed to assess patients for any Primary Health, Mental Health, Drug and Alcohol and/or Population Health issues that require immediate or ongoing treatment. When further management of any identified conditions is required, a waitlist entry must be made via the Patient Administration System (PAS) for the appropriate health specialist.”
32. There are algorithms built into the RSA to support clinical decision-making by making recommendations for referral to Custodial Mental Health Services or the Risk Intervention Team, based on responses to screening items.
33. RN Cooksley's RSA of PE records that PE denied having a mental health history or symptoms, denied feeling depressed and denied having any suicidal or self-harm intentions. It is recorded

that PE told RN Cooksley that it was his first time in prison, he denied there was anything causing him concern, and he said he would be able to cope in prison.

34. It appears that PE's responses did not trigger an algorithm-based recommendation that he be referred to a mental health nurse. Nevertheless, RN Cooksley completed a mental health referral based on his own observations of PE. Those observations are recorded in the RSA as PE presenting as "slightly depressed re charges" and in PE's progress notes as "looks flat a bit withdrawn". In his explanation for why the referral was made, RN Cooksley has recorded: "situational depression". RN Cooksley told investigators: "I don't remember what exactly it was about [PE] that prompted me to write this. It was his first time in custody and this can be a risk factor for situational depression".
35. RN Cooksley made the referral through the Patient Administration System (PAS) system. He listed the referral as Priority 2 semi-urgent, meaning that, subject to resourcing, PE would probably be reviewed within 14 days by a mental health nurse.
36. RN Cooksley also completed a Health Problem Notification Form (HPNF) regarding PE. A HPNF is intended to contain "limited but important information about a patient's health status for use by Correctional Officers and provides a recommendation for appropriate cell placement. The HPNF also helps the Correctional Officers to understand the patient's health needs." The HPNF directs Correctional Officers to monitor for signs and symptoms as documented on the HPNF and to report any relevant observations to health staff.
37. The signs and symptoms RN Cooksley identified on PE's HPNF were: First time in gaol; No self-harm issues; MH monitor for isolation. In his statement, RN Cooksley explains that he made a HPNF recommendation that PE be placed in a group cell placement until he had been cleared by the mental health team as a protective measure. In my view this was appropriate.
38. The evidence establishes that PE was placed in Area 6B of Parklea that first evening, which is known as the "first night accommodation wing". Placement in Area 6 for a new inmate is consistent with MTC Australia Policy, 5.02 Inmate Reception.
39. Area 6B was opened in 2020 and was designed to modern prison standards, including being fitted with anti-ligature features to reduce the risk of hanging. The evidence from former Parklea Governor Wayne Taylor is that fresh custody inmates are placed in Area 6B to allow them to acclimatise to the prison environment in a safe and secure setting. Area 6B holds fresh custody inmates whilst they are awaiting a placement decision.
40. PE was placed in a "two out" (or in two person) cell in Area 6, in accordance with St Vincent's HPNF recommendation, at around 10:20pm.

Events of 31 January – 2 February 2024

41. The next morning, 31 January 2024, at about 11:20am PE underwent an Intake Screening Questionnaire (ISQ) conducted by Correctional Officer Gail Hulett. Consistent with Mr Taylor's evidence, Ms Hulett explained that PE would have been locked in his cell until the ISQ was conducted "for the inmate's safety, as well as safety of others".
42. The ISQ in use at Parklea as at January 2024 was produced by CSNSW and was the subject of evidence.
43. An ISQ is completed for each inmate who enters custody for the first time, or who enters on fresh charges. At Parklea, an ISQ must be completed within 48 hours of the inmate's arrival, however this can be extended depending on other factors. An ISQ is conducted by a trained ISQ screener and is then reviewed by the Checking Officer who is usually the supervisor of the ISQ team.
44. Correctional Officer Hulett's statement states "the purpose of the ISQ is to identify the risk of harm that the inmate poses to themselves or others, as well as to gather information about behavioural and mental health issues and personal needs at the time of admission. The information collected contributes to Centre's [Parklea's] management of the inmate, including management of risks identified during the ISQ process."
45. The court had the opportunity to review PE's ISQ. Recorded within that document is a comment that PE had thought about taking his own life at the police cells when he was first arrested, but that he denied any current plans to self-harm or suicide. When asked how he was feeling, it is recorded that PE replied: "not real good, locked in is hard".
46. PE told CO Hulett that he had the support of his wife and mother and that when he is stressed in his relationships he would "talk to someone."
47. Correctional Officer Hulett gave oral evidence. She told the court that she considered that PE's answer that he was finding it hard to be "locked in" was in relation to his having been kept in his cell until the ISQ was completed. She advised that this is a common response, and that the answer, on its own, would not factor into her risk assessment. Similarly, PE's earlier thoughts of self-harm did not strike CO Hulett as unusual for someone fresh in custody, and that she makes a wholistic assessment as to whether an inmate has current plans. Overall, she assessed that PE did not appear to be at risk of self-harm or suicide at the time of the ISQ.
48. As part of the ISQ process, CO Hulett facilitated a phone call between PE and his wife, LE. This "welfare call" is not paid for by the inmate, many of whom would not have money in their account to make calls at this early stage. CO Hulett's usual practice is to recommend that the

inmate tell the recipient important information such as how to put money in the inmate's account. CO Hulett made a note that PE's wife "sounded supportive".

49. LE recalls that during the welfare call, PE asked her to bring his reading glasses and his mother's phone number so he could call her to let her know what was happening. Later that afternoon, LE went to Parklea and dropped off PE's reading glasses. She attempted to hand over a letter with PE's mother's phone number but she was apparently told they were unable to take the letter, only his glasses.
50. This telephone call was the only contact between PE and LE during his time in custody. LE thought it was 'strange' that PE had not called her again.
51. PE completed a phone number form with CO Hulett listing LE's mobile phone number. The purpose of this form is to enable inmates to use the Offender Telephone System (**OTS**). The numbers listed by an inmate are checked and, where appropriate, approved by a correctional officer. Once the check has been completed, the form is provided to the inmate accounts team to process and activate the phone numbers on the inmate's OTS account. PE's phone form was apparently processed by the inmate accounts team that same day.
52. At the conclusion of the ISQ, CO Hulett made a recommendation, supported by PE, that he be placed under a Special Management Area Placement (**SMAP**) order due to the nature of his charges. CO Hulett's SMAP recommendation was approved. The court was informed that:

"A Special Management Area is a designated area within a [correctional] centre where inmates may be housed when an assessment of their individual needs/circumstances has found they are vulnerable or at risk from other inmates in the normal discipline area of the correctional centre. Inmates held in this area associate freely with each other and have access to programs and services similar to inmates housed in normal discipline."
53. On 1 February 2024, at about 12:45pm, PE was moved into Area 2D of Parklea. This area is designated within Parklea to house SMAP inmates. PE was placed in cell 35 with another SMAP inmate. The decision to place PE with another inmate appears to have been in accordance with *COPPS 3.3 Special Management Area Placement* and consistent with the St Vincent's recommendation that PE be placed in a group cell. It was appropriate in all the circumstances.
54. Area 2D is part of the original infrastructure of Parklea and pre-dates the development of modern anti-ligature point design principles. The bunk beds in Area 2 are older style beds that have open rung ladders, some have open slats, guardrails and gaps through which ligatures can be threaded. There are numerous and obvious other points in the cell which could be used for hanging.

55. Also on 1 February, at 10am, LE transferred \$100 into PE's trust account, which was received on 2 February 2024. It appears PE already had about \$180 in his trust account as at 1 February received from "other sources". Mr Wayne Taylor agreed that this may have been cash PE had on him at the time of his arrest. In order for PE to be able to make phone calls with this money, he was required to request a transfer of his trust funds into his OTS account. PE did so on 1 February and \$50 landed in his OTS account at 3:30pm on 2 February 2024.
56. In the meantime and before those funds were available, PE attempted, unsuccessfully to call LE's mobile phone number twice at 10:37am (recorded result: PIN Limit) and at 12:24pm (recorded result: Funds Expired) 1 February 2024. PE successfully called Legal Aid that same day and had a 10-minute conversation – this was possible because calls to Legal Aid are free.
57. Again on 2 February 2024, PE attempted to phone LE's mobile at 9:33am without success (recorded result: Funds Expired).
58. PE's cellmate stated that PE had told him that he had tried to call his family but that "he couldn't get through". PE confirmed that he had already provided LE's number for approval. PE's cellmate states that he told PE, "you have to put money into your account before you can make a phone call otherwise the operator, you can hear the operator saying, there's insufficient funds, and they'll hang up". On the evidence available, it is not clear whether this is what prompted PE to request the funds transfer or whether transfer had already been requested but not yet actioned.
59. PE's cellmate says that he and PE stuck together in the yard on Friday 2 February 2024 and they walked together for exercise. They were locked into their cell at about 3:20pm that afternoon. PE's cellmate reports that he didn't notice anything "unusual" that evening and they agreed to watch The DaVinci Code on TV, which finished at 11:30pm. Once it had finished, PE's cellmate turned the TV and lights off, removed his hearing aids and glasses, put on his sleep apnoea mask and went to sleep in the bottom bunk.
60. This activity is highly suggestive of PE's death occurring in the very early hours of 3 February 2024 as PE is likely to have waited until his cellmate had settled into sleep and he had time to make the necessary arrangements in private.

Events of Saturday 3 February 2024

61. The next morning, PE's cellmate told investigators that he woke needing to use the toilet. He rolled over and was surprised to see the window shade closed. He got out of bed and saw PE's foot on the ground. When he stepped forward he saw PE with his body suspended in the air. It was immediately clear that PE had hanged himself using a ligature torn from a bedsheet.

62. PE attempted to untie the knot where it was attached to the top bunk but he couldn't make it budge. He activated the cell alarm to summon assistance at 8:10am. The first responding officers arrived at cell 35 without delay.

63. The CSNSW Serious Incident Report dated 26 March 2024 was contained within the brief. It stated:

“From review of the cell call alarm activation audio and CCTV-BWC footage, it is apparent that first responding officers attended cell 35 promptly and provided CPR to [PE] immediately and continued to do so on the arrival shortly afterwards of St Vincents Health staff and then NSW Ambulance Paramedics.”

64. NSW Ambulance were contacted at 8:11am by Correctional Officers and the first team of paramedics were with PE by 8:22am. Resuscitation efforts continued but, tragically, PE could not be revived. He was pronounced deceased at 8:30am.

65. It appears that the emergency response to PE by MTC and St Vincent's personnel was in accordance with the applicable policies and procedures.

Autopsy

66. A post mortem examination took place on 7 February 2024. The forensic pathologist, Dr Lorraine du Toit-Prinsloo, concluded in her post-mortem report that the direct cause of PE's death is 'in keeping with hanging'. I accept her opinion on this issue.

67. The toxicology results detected no drugs or alcohol in his system.

Issues

68. An issues list was circulated prior to the inquest commencing and I will now deal with each issue in turn.

The date, place and medical cause of death of PE.

69. There was no real dispute in relation to the date, place or medical cause of PE's death. The evidence establishes that PE died in the early hours of 3 February 2024 at Parklea Correctional Centre as a result of hanging.

Was PE's death self-inflicted?

70. A finding that a death is self-inflicted should never be made lightly. The evidence should be cogent and persuasive, especially in relation to a person with no known history of suicidal ideation in circumstances where no final communication has been located or identified. I note that early in the investigation those closest to PE found it difficult to accept that he would have

ended his own life and I have taken that into account. Nevertheless I am comfortably satisfied that PE's death should be recorded as intentionally self-inflicted.

71. In coming to that conclusion I have had regard to the fact that there is no evidence of PE having had contact with any person other than his cellmate after being locked in his cell. This was confirmed by CCTV of the cell entrance. PE had no defensive injuries, there was no sign of a struggle and no suggestion of any ill will between the men. PE's cell mate was 70 years of age and would not have had the strength to overpower PE. In fact he found it difficult to lift PE when he made attempts to assist him on the morning of 3 February 2024. I am satisfied there are no suspicious circumstances.
72. Secondly, deliberate actions appear to have been taken by PE, which are not consistent with his death occurring as a consequence of an accident. The bedsheet was ripped and crafted into a ligature. There was also evidence that PE may have taken steps to conceal his actions by closing the window shutter to reduce light in the cell.
73. I find PE's death was intentionally self-inflicted at a time of emotional turmoil.

The adequacy of PE's intake screening at Parklea Correctional Centre.

74. I have carefully considered the attempts made to assess PE's risk of suicide during the various processes that were undertaken at Parklea Correctional Centre.
75. The initial RSA was undertaken by a very experienced nurse, RN Cooksley. His statement made it clear that he was well aware of the need to build rapport when undertaking the RSA process. He explained that he did not just read a script from the computer, which might appear "robotic", rather he always tries to engage in a conversation to make the patient feel more comfortable. He also stated that he is flexible about when formal observations such as a temperature and heart rate are taken during the interview, as he is keen to establish rapport and encourage a calm atmosphere. RN Cooksley understood the need for plain English, and advised that he carefully examines demeanour and always looks for signs of disguised distress such as any incongruency between what "they say and how they behave".
76. The court was well satisfied that RN Cooksley's approach was thorough. It is noteworthy that while the RSA algorithm did not mandate a mental health assessment, RN Cooksley determined that it would be appropriate given what he identified as the possible existence of situation depression in PE.
77. The next part of the procedure is the ISQ which was conducted by CO Hulett the following day. The Court heard directly from CO Hulett. She was a thoughtful witness whose demeanour suggested she was trying to assist the court in its investigation. She had specialty training as

a screener, as well as having other correctional experience. At the time of undertaking PE's assessment CO Hulett had been screening inmates for approximately two years.

78. CO Hulett gave evidence about her usual practice when conducting ISQs. She explained the following:

- a. Before commencing the ISQ with the inmate, CO Hulett will review all information that is available to her including the St Vincent's RSA Summary⁶ and the HPNF. Her evidence is that she places great value on these documents as they have been prepared by someone who is medically trained.
- b. It is CO Hulett's usual practice "to ask the inmate about current thoughts of self-harm or suicide a number of times, sometimes in different ways in order to test whether the inmate is providing an honest answer to me".
- c. CO Hulett's evidence oral evidence was that this is the practice she has developed to "make sure they're ok, particularly if it's their first time in custody".
- d. CO Hulett emphasised in her statement that she would not have looked at PE's answer that he had thoughts of taking his own life when in the police cells in isolation, her practice is to look "at the screen as a whole to ascertain whether the inmate has current plans".

79. CO Hulett's evidence was consistent with the evidence of Ms Crosbi Knight from CSNSW, who told the Court that screeners are trained to treat the ISQ assessment as a holistic process where answers are considered in context:

"A holistic assessment involves observing the inmate's overall presentation throughout the interview, considering all responses, and noting how they present during the phone call. Screeners are encouraged to make the process interactive by engaging the inmate, encouraging questions, and providing opportunities for clarification. This approach is particularly important for inmates who are in custody for the first time or who present with vulnerabilities such as instability, age-related concerns, or mental health issues".

80. Ultimately, CO Hulett determined that PE's screen did not present as high risk and he "did not stand out as an inmate that needed to be treated as being at risk of self-harm or suicide".

81. Expert Psychologist, Dr Seidler confirmed that in her view the RSA and ISQ both include questions that are appropriately directed at assessing suicide risk. She stated:

⁶ "Due to health privacy principles, officers are not provided the whole assessment and only receive this summary": Hulett - Tab 69, p 4 [15(a)].

“it is important in assessing suicide risk that direct questions about suicidality and self-harming behaviour are asked. This is reflected in the questions identified on the various assessment screens conducted with [PE] and I assume the assessor would ask the questions identified. Further to this, it is important that questions are designed to reflect the factors known to be associated with suicide risk, across both the cognitive (i.e., thinking/ideation) and behavioural domains (e.g., have you tried to kill yourself?, have you thought about killing yourself?). It is apparent that again, this was covered in the assessments with [PE] in custody”.

82. Dr Seidler told the court that suicide is very difficult to predict and explained some of the issues involved. She advised that that suicide risk is dynamic and people can change their mind; that any assessment is only as good as the information provided; and that someone may not be forthright about their thoughts or intentions.
83. Overall, it was her opinion that the screening of PE by St Vincent’s and MTC was adequate and that his risk of potential suicide or self-harm was appropriately assessed. Specifically she advised the court that she was not aware of any research that suggested those charged with sexual offences have a higher risk of suicide. Rather, Dr Seidler advised that violent offenders presented as the offending group most at risk of suicide.
84. When considering the possibility of improvements to the current system, Dr Seidler suggested that the ISQ might be amended to include questions directed at assessing an inmate’s vulnerability to suicide should his or her mental state deteriorate in the future. This could be done by the asking of specific questions. In response, Ms Crosbi Knight from CSNSW remarked that the questions proposed by Dr Seidler “are appropriate and well-intentioned”.
85. Ms Knight advised the court that the ISQ is reviewed regularly and its next review is due at the end of this year. This will involve consideration of whether the questions can be better focused and reduced in number, having regard to the timing of the ISQ when inmates are fresh in custody and may be feeling confused and not ready to engage.
86. The court was satisfied that there is a process of ongoing review in relation to potential improvements to the ISQ.

Whether the cell placement and checks of PE were appropriate and/or sufficient.

87. With respect to this issue, as noted earlier, PE was placed in a SMAP area of the jail due to safety fears and was in a “two out” cell in accordance with the St Vincent’s recommendation.
88. Dr Seidler, who has considerable experience working as a psychologist in a custodial setting, told the Court that placing inmates “two out” is considered to be a protective measure because

inmates are less likely to engage in self-harm behaviours with another person in the cell. The cell mate can be a distraction and a source of company and conversation. The next step up is placing the prisoner on an observation regime. This can be intrusive and cause escalation in some prisoner's levels of anxiety. Dr Seidler told the Court that she considers that PE's cell placement and the absence of a mandated observation regime were appropriate. I accept her view on this matter.

89. On the basis of the screening assessment, PE was not considered to be at imminent risk of suicide and, therefore, was not subject to an observation regime or placed on a RIT (supervision by a Risk Intervention Team) Instead, the evidence of Mr Taylor is that PE would have been observed incidentally throughout the day by Correctional Officers as part of the daily routine, but unobserved after lock-in, except by his cell mate. Mr Taylor stated that "correctional officers are trained to observe inmate's behaviours throughout these interactions and to report unusual behaviour..." A review of PE's custodial records confirms that no case notes of relevance were recorded in OIMs.

90. After the evening medication round, at about 6:30pm, there are no physical observations or checks of inmates until morning head count at about 8:30am. Mr Taylor explained:

"observations or checks are not routinely made on inmates in their cells after they are locked in unless an inmate is on observation protocols. To do so would cause sleep disruption to inmates and would therefore cause wider disruption to the good order of the wings in which inmates are housed".

91. I have carefully considered the available evidence and I find that, on the information available to staff at Parklea, a two out cell, rather than an observation cell was appropriate on the evening of 2 February 2026.

The presence of hanging points in PE's cell.

92. Like many coroners Australia wide, I have been concerned about the ongoing existence of hanging points in custodial environments for many years,⁷ frequently making recommendations for urgent changes to be made. While CSNSW has made some changes to specific areas, in my view more work needs to be done. It must be remembered that while MTC is funded to maintain and operate Parklea, funding for large-scale ligature reduction works is dependent on obtaining funding approval from CSNSW.

93. The cell where PE was housed was in cell 35, area 2D. It had a number of obvious ligature points which present significant self-harm risks for vulnerable inmates on remand. The Court

⁷ See for example *Inquest into the death of Kerry-Ellen (Nikki) Knight* 28 September 2022, *Inquest into the death of DP*, 16 November 2023

heard evidence that the problems in Area 2 are well-known but that capital funding from CSNSW to complete “whole of cell” upgrades, or even to replace the bunk beds in Area 2D, has not been granted during MTC’s involvement in the gaol – that is since March 2019.

94. In November 2023 I recommended that *“the Commissioner Corrective Services NSW should continue to seek additional funding for the program of cell refurbishment, to progress the removal of obvious ligature points from cells in correctional centres as a matter of urgency.”* This recommendation arose from the death of a prisoner housed in Area 1 of Parklea in April 2021 and is yet to be actioned.⁸
95. Clearly the expense of removing ligature points from all cells is prohibitive from CSNSW’s point of view and cost remains the most intractable barrier to reform. Mr Taylor addressed some of the other complexities surrounding the issue from his perspective. For example he cautioned against the efficacy of a piecemeal approach to cell design, when a more wholistic approach is required. Nevertheless, reception and remand prisoners are known to be particularly vulnerable. Mr Taylor stated that there may be more latitude to place a settled and sentenced prisoner, known to the system, in a “problematic cell”, than exists with an unknown, fresh inmate experiencing custody for the first time.
96. I remain of the view that Parklea’s remand cells need urgent refurbishment. No evidence was provided that would give this court any confidence that there are future plans for the refurbishment of Area 2 cells at Parklea once it is returned to state control on 1 October 2026.
97. In my view the issue remains one of extreme concern.

The presence of the makeshift privacy screen in PE’s cell.

98. This issue relates to PE’s cellmate’s placement of a bed sheet across the back of their bunks to create a makeshift privacy screen for using the toilet. PE’s cellmate told investigators that he knew it was against the rules but he considered it was “a normal practice” at Parklea. His evidence was that they were not asked at any time by a Correctional Officer to take down the sheet and it was still erected when he discovered PE in peril on 3 February 2026.
99. The erection of privacy screens fashioned from blankets and towels is a common practice in all NSW custodial settings, not just Parklea. Some prisoners understandably use screens to provide themselves with some modicum of privacy in the gaol environment. They are sometimes erected so that prisoners can shower or use the toilet without being watched, but they are also undoubtedly used to hide activities which are forbidden. Clearly they have the capacity to reduce cell safety if correctional staff’s view into the cell is obscured.

⁸ *Inquest into the death of DP*, 16 November 2023.

100. Both Mr Taylor and Mr Brown accepted the existence of a system wide issue. Mr Taylor said that the practice of a privacy screen would not be tolerated for an inmate who is under observations but, for others, it is a “struggle” to strike the right balance. The prison is their home and they are living with other people and you “have some empathy about two people living in close proximity”. It is about “basic human principles of decency”. Both suggested that modern cell designs which use low partition walls to provide privacy may be the way of the future.
101. Mr Brown gave consistent evidence that the practice is tolerated to provide dignity to inmates. One approach that may be taken by senior staff is to ask the inmate to take the sheet down when it is not in use. He stated “this doesn’t always work, but with some there can be agreement”.
102. Ms Seidler had the following to say on the issue:

“Unfortunately, I do not consider there is anything I can offer to assist in meaningfully resolving this tension further. This is an ongoing challenge for the Correctional system and I can appreciate both sides of the argument. Correctional staff need to be able to observe and sight inmates when needed for a number of reasons, including managing the risk of self-harm. One could also argue that committing a crime and being incarcerated means that an individual forgoes certain comforts and dignities that go along with freedom. However, this needs to be balanced with human rights and basic dignity for individuals even if they are in prison. Moreover, there is a long history of correctional environments and systems that have not promoted basic human rights, comforts and privacies for inmates and this can make the environment more challenging to manage for staff, as prisoners are more likely to act out and resist such an environment”.

103. The issue was examined briefly at the inquest, although it is accepted that given the time of PE’s death, it likely had no bearing on his demise.

Whether the current policies around remand inmate phone calls are sufficient.

104. Telephone access continues to be a vexed issue in the custodial environment. The Inspector of Custodial Services reported that between 1 July 2024 and 30 June 2025, 1,144 complaints were made to Official Visitors in relation to phones. That amounts to 5.70% of total complaints made and was the third highest topic of complaints.
105. When PE was in custody in early 2024, the operative CSNSW telephone policy prescribed that remand inmates were entitled to three free personal phone calls per week to a local landline

number. Once those free calls were exhausted, phone calls to local landlines were charged at 35 cents and phone calls to mobiles were charged at approximately \$1.10 each.

106. The obvious problem for PE is that he was trying to call LE's mobile phone before his money had cleared.
107. There is no doubt that social support is vitally important to an inmate's wellbeing. Although support can take other forms, a focus of this inquest became PE's inability to contact his wife LE by telephone at a critical time. Dr Seidler told the court that social support can build resilience, it can be protective against suicide, and it can reduce the risk of recidivism.⁹ I accept her opinions on these issues.
108. Dr Seidler gave evidence that resilience in a prisoner is important because, "going to prison is a confronting, significant life event with a significant effect on mental health. You have to use your resources to cope with it. Social support is one of the factors that helps with resilience. Particularly if you are in custody and feeling connected to the community."
109. The importance of telephone calls in the prison environment is well recognised. Contained within the brief is a news article by Eelemarni Close-Brown. The article contains comments from Dr Rory Gillard from the Community Restorative Centre (CRC), a community organisation supporting people impacted by the criminal justice system. Dr Gillard states:
- "The cost of phone calls in prison can sometimes force people to make heartbreaking decisions between buying basic essentials they need in prison and maintaining regular connections with their loved ones".*
110. The article also states that only 17% of Australian adults had a landline phone that they used for personal purposes.
111. A report by the Australia Communications and Media Authority regarding communication trends found that the use of landlines by Australian adults in the six months prior to June 2025 was at 12%, down from 15% in 2024. It is likely landline usage has continued to drop.
112. Having carefully considered all the evidence I am satisfied that it is likely that the lack of contact with LE was a contributing factor to PE's declining mental health and his ultimate decision to take his own life. Certainly, that is LE's view. The evidence that tends to support this finding, includes,
- a. The expert evidence that a lack of social support can be a risk factor for suicide.

⁹ Newspaper article Tab 95, p 3. Dr Seidler supported this in oral evidence: "pro social support, support that discourages reoffending can reinforce an individual not to engage in criminal acts...it hopefully reduces ill mental health, substance abuse and contributing factors to offending behaviour".

- b. The evidence that PE and LE were exceptionally close.
- c. The evidence that PE considered LE to be a major support to him.
- d. The evidence that PE liked to “talk to someone” when he was stressed in his relationships.
- e. The evidence that PE was seeking out contact with LE and had complained to his cellmate when he was unable to get in touch with her.

113. The Court heard evidence that inmates now receive one free mobile phone call per week.

114. In circumstances where there are obvious benefits to inmates in having phone calls with loved ones and, in the contemporary context where landline use is in ongoing decline, it is difficult to accept that one free mobile phone call per week is sufficient. This conclusion was not controversial. In fact, each of the executive and expert witnesses in these proceedings appeared to accept that inmates should receive more free phone calls, including to mobile phones.

- a. **Mr Taylor** from MTC acknowledged that connectivity with the outside is supported by MTC and that is why they lobbied for inmate tablets. He said that his personal view is that fresh custodies on remand should receive free calls for a set period – definitely in the first two months - while they are familiarising themselves with the environment. He noted that female inmates in particular are financially disadvantaged compared to men, and may be hampered in making calls if they are not subsidised or free.
- b. For sentenced inmates, Mr Taylor considered that free phone calls could be used to incentivise them on their journey through the custodial system.
- c. Mr Taylor cautioned against rushing in and assuming that “one size fits all”, however he said that “unlimited calls would be great in the right circumstances and with the right policy framework”.
- d. **Ms Renee Van Aaken** from CSNSW told the Court that she was part of the recent negotiations to provide inmates with one free mobile call and that this was agitated because there is an organisational acceptance that landlines are being used less. She confirmed that when contract negotiations begin again that CSNSW would be seeking more free mobile calls for inmates.
- e. **Mr Brown** said that he would support inmates having more free phone calls, especially in times of need such as entry to on remand when inmates may require more support is required due to the “uncertainty” of their situation.
- f. **Ms Knight** said that, putting aside cost factors, she would have no objection to inmates receiving more free calls, in particular remand inmates who are dealing with sudden “emotional and logistical adjustments” upon their entry into custody.

- g. **Dr Seidler** makes a recommendation in her report that consideration be given to first-time remand inmates having *“a number of additional free calls to their personal supports in the community prior to their phone accounts being activated”* given this cohort’s increased risk of suicide/self-harm.
- h. In her oral evidence, she said that the lack of access to communication is a source of frustration in prisons. It makes difficulties for correctional officers to manage frustrated inmates. For remand inmates in particular, she opined that more free calls would bring positive benefits.

Related matters: inmate tablets, secure text messaging pilot and OTS account activation

115. It is an appropriate juncture to acknowledge three related matters:

- a. *Firstly*, that CSNSW intends to roll out Offender Tablets (OTABS) at Parklea when it is returned to state control. The provision of tablets has been an extremely positive initiative for inmate wellbeing in the state controlled system and one that MTC has actively pursued during their contract. It is pleasing to learn that the inmates at Parklea will soon enjoy the same advantages that prisoners in state-run facilities have had for some time, including the ability to make phone calls from their cell after lock-in. Ms Van Aaken told the Court that the OTABS have already been ordered, that infrastructure upgrades will commence in October 2026 and that, at a guess, it will take about six months for the system to become operational. It is difficult to understand why this could not have happened years ago.
- b. *Secondly*, that CSNSW intend to trial a pilot program which will provide a secure text messaging platform for inmates as a low cost way to message approved contacts using OTABS. This plan is reported to be in the final stages of technical development. It is a positive development.
- c. *Thirdly*, that CSNSW is actively considering the creation of an administrative team dedicated to speeding up the process of having phone numbers approved and OTS money transferred that will operate seven days per week. As the evidence currently stands, it appears that these vital prerequisites to accessing phone calls through the OTS are currently not actioned over the weekend.

116. In LE’s view, this would have been significant for PE. She told investigating officers:

“I strongly believe [PE] did not take his own life. And I think if he did do this to himself by him not being able to talk to me for a number of days has added to it. Why would he not be allowed to talk to me for days, and especially being the first time, he had ever been to jail. This would have been a contributing factor. We were never apart at any time during our relationship.”

117. It appears that since the second half of 2025, CSNSW has subsidised one free mobile phone call per week for all inmates. This is a common sense development given the declining use of landlines in Australia – indeed, one statistic from CSNSW is that only 30% of calls made by inmates are to landlines.¹⁰

Is it necessary or desirable to make any recommendations pursuant to s 82 of the Coroners Act 2009?

118. Section 82 of the Coroners Act 2009 confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of the individual death.

119. Counsel Assisting put forward three draft recommendations directed to the Commissioner of Corrective Services for consideration. It is appropriate to note that I was well satisfied that CSNSW made a genuine effort to engage with the issues raised during the inquest and in counsel assisting's final address. However, this meant that some of the information included in CSNSW's final submissions was fresh evidence and while useful was not tested in the usual way.

120. I will deal with each of the draft recommendations in turn.

Recommendation One

Immediately for unsentenced inmates, CSNSW is to meet the costs of their first four personal calls each week made to *either* an Australian mobile phone number or a landline number (local and national).

121. Counsel assisting submitted that there was clear evidence that unsentenced inmates were at particular risk and that this cohort would benefit from more support to maintain contact with their loved ones at this critical time. Counsel assisting submitted that the recommendation called for a modest increase given that prisoners are already afforded one free mobile call and three free landlines calls per week. The overwhelming evidence that landlines are increasingly rare supports an adjustment to the current policy.

122. CSNSW accepts that inmate telephone usage has shifted significantly towards mobile numbers reflecting a broader community trend in declining landline use. CSNSW stated that

¹⁰ *NSW prison phone call costs made it hard for Chris to stay connected to his family. Advocates say they should be free*, Sydney Morning Herald, 1 September 2025: Tab 97, p 3. According to the ACMA: household landline use is in continued long-term decline. Only 12% of Australian adults used a landline phone in 2025, down from 15 per cent in 2024 and 54% in 2017. EXHIBIT 3.

in NSW correctional centres the majority of inmate calls are now made to mobile numbers (66%) and landline usage continues to decrease.

123. CSNSW submitted that it supports the *principle* of the proposed recommendation. It accepts that access to telephone calls can provide inmates with beneficial pro-social support, particularly unsentenced prisoners like PE. However it advised the Court that there were a number of significant financial and resourcing constraints.
124. The Court was advised that call rates for inmate phone calls are contractually set and have reduced over time. However, mobile calls remain significantly more expensive. Within CSNSW correctional centres mobile calls cost \$2.24 per 10 minutes and landline calls are charged at a flat rate of 25 cents.
125. The court was advised that in 2024 to early 2025 CSNSW commenced negotiations with Telstra to reduce call costs and a reduction was made from 8 September 2025. CSNSW submitted that it will continue to renegotiate call rates at “appropriate contract points”. CSNSW provided a table which compared prison phone costs across jurisdictions and submitted that NSW rates “currently sit at mid range nationally.” While this may be true, given the information came at the end of the inquest, there was no opportunity to drill down into assertions contained in the table and be certain that like costs were always being compared. Nevertheless I note on the information provided that calls in Western Australia Correctional Centres are significantly cheaper.¹¹
126. On rough figures, CSNSW stated that the proposed recommendation would “equate to approximately 1.2 million calls per year and cost around \$2 million per annum plus approximately \$280 000 per annum in other charges.” This previously unfunded cost was described as substantial and a stumbling block to CSNSW supporting the recommendation in its current form. I expect this rough figure is based on assuming that all unsentenced inmates take up the maximum number of free calls, but it is not entirely clear.

¹¹ CSNSW included the below table regarding the costs of calls from custody around Australia:

| State/Territory | Typical Cost (Mobile Calls) | Cost of ~10-12 min Call | Notes |
|------------------------------|-----------------------------------|-------------------------|-------------------------------|
| Victoria | ~25c per minute | ~\$3.00 (12 min) | Reduced Feb 2025 |
| New South Wales | ~24-26c per minute | ~\$2.24 (10 min) | Updated Sept 2025 |
| Queensland | ~20c per minute | ~\$2.00 (10 min) | Digital upgrade reduced costs |
| Western Australia | ~10c per minute | ~\$1.20 (12 min) | Cheapest in Australia |
| South Australia | ~30-40c per call (local landline) | ~\$0.30-\$0.40 | Mobile calls cost more |
| Tasmania | ~30-40c per call (landline) | ~\$0.30-\$0.40 | |
| Northern Territory | ~40c per minute | ~\$4.80 (12 min) | Amongst the highest |
| Australian Capital Territory | 18.7c per minute | ~\$2.25 (12 min) | Reduced late 2024 |

127. Given its stated commitment to enhancing communication for inmates, CSNSW put forward the following alternate draft recommendation for consideration.

CSNSW is to review COPP 8.2 Inmate Telephones and related phone policies and procedures to consider increasing access to personal telephone calls for unsentenced inmates to either an Australian mobile phone number or landline number (local or national). The review will include consideration of the following initiatives

- a) Renegotiation of call rates at appropriate contract points to reduce landline and mobile call charge rates for inmates*
- b) A centralised processing model for phone numbers and phone money at large remand centres to expedite the activation of inmates OTS accounts, and*
- c) Automatic phone account credit for inmates on reception to ensure calls are automatically available upon entry into custody.*

128. I have considered the issues raised very carefully and while it is difficult to properly assess the resource burden on the rough figures supplied by CSNSW in their final submissions, I accept the current contract likely hampers CSNSW's ability to make substantial change *immediately*. In my view there is a clear need for contract negotiation. Call rates appear to be charged at a high rate in the NSW custodial environment and it constrains what CSNSW is currently able to offer vulnerable prisoners.

129. In my view the contract should be renegotiated again *immediately*, rather than at the somewhat vague "appropriate contract points". I will make the recommendation in the amended form with that single variation.

Recommendation two

CSNSW is to review their phone policies for inmates in the context of the steady decline of landline usage and ownership in Australia. In particular, the feasibility of offering an unlimited number of free telephone calls to mobile numbers and landlines to all inmates should be investigated and consideration be given to implementation.

130. Counsel assisting submitted that CSNSW's current policy is less than optimal and requires review in the context of declining landline usage. I accept this submission.

131. As stated above CSNSW agree that telephone calls are crucial for inmate wellbeing. CSNSW submitted that it "largely agreed" with the proposed recommendation but put forward an alternative recommendation where "unlimited" calls was replaced with "an increased number of free or reduced rate calls."

132. CSNSW submitted that implementing recommendation two as it stands would involve a cost of almost \$20 million per annum, using the current rates, if call usage remained at 2024 levels. The figures have not been tested. Nevertheless, I have considered the cost issues raised. Realistically CSNSW is hampered by its prior contractual commitments. I have decided to make the recommendation in its amended form.

Recommendation three

That as a matter of urgency, CSNSW is to establish a team to expedite the verification of phone numbers and the transfer of inmate trust account funds into their OTS account. That team is to operate 7 days per week.

133. The evidence before me during these proceedings was that there is no capacity to verify and transfer funds after hours or on weekends. This can result in leaving inmates unsupported even when they have the funds to commence a telephone account. In PE's case he was thwarted in contacting his wife at a critical time after his reception at Parklea.

134. At the conclusion of proceedings counsel assisting requested consideration of a third recommendation following evidence that a seven day a week administration team is being "actively considered" by CSNSW. I accept the issue is an important one.

135. In final submissions CSNSW's representative stated that the recommendation was not necessary as she was able to provide further information about this proposal. The Court was advised that the establishment of a centralised "Authorised Inmate Contact Team" is well advanced and "is currently before the Treasury and Expenditure Review Committee (ERC) for consideration". It is anticipated that the ERC process via cabinet will be finalised by the end of this financial year.

136. CSNSW also advised that the "improving Connections" project aims to find a number of ways to reduce delays in accessing the OTS.

137. For these reasons it was submitted that the court could be confident that the issue is well understood and currently the focus of numerous strategies for improvement. I accept that submission and decline to make the recommendation.

Findings

138. For the reasons set out above, I make the following findings pursuant to section 81(1) of the *Coroners Act*:

Identity

The person who died is PE.

Date of death

He died on 3 February 2024.

Place of death

He died at Parklea Correctional Centre, in area 2.

Cause of death

He died from hanging.

Manner of death

PE's death was intentionally self-inflicted.

Recommendations

139. For reasons set out above, I make the following recommendations pursuant to section 82 of the *Coroners Act*.

To the Commissioner of Corrective Services NSW:

- 1) *CSNSW is to review COPP 8.2 Inmate Telephones and related phone policies and procedures to consider increasing access to personal telephone calls for unsentenced inmates to either an Australian mobile phone number or landline number (local or national). The review will include consideration of the following initiatives:*
 - a) *Immediate renegotiation of call rates to reduce landline and mobile call charge rates for inmates*
 - b) *A centralised processing model for phone numbers and phone money at large remand centres to expedite the activation of inmates' OTS accounts, and*
 - c) *Automatic phone account credit for inmates on reception to ensure calls are automatically available upon entry into custody.*
- 2) *CSNSW is to review their phone policies for inmates in the context of the steady decline of landline usage and ownership in Australia. In particular, the feasibility of offering an increased number of free or reduced rate calls to mobile numbers and landlines to all inmates should be investigated and consideration be given to implementation.*

Conclusion

140. The inquest shone a light on a variety of extremely important issues relating to telephone access for remand prisoners. While hampered by prior contractual arrangements, CSNSW see the need to offer remand prisoners a better communication service. I hope a review of the current telephone policies will lead to further change in the context of ever decreasing landline use. In my view, increasing opportunities for unsentenced prisoners to make contact with their loved ones has the capacity to help save lives in the future.
141. The inquest also once again highlighted the risks involved in placing a remand prisoner in an unsafe cell. While I accept that in this case the screening process was in accordance with policy, it remains a fact that suicide is extremely difficult to predict. While hanging points remain part of our custodial architecture, men like PE are at risk. The fact that I did not make a recommendation about hanging points does not suggest the issue is unimportant, it merely reflects the fact that I have made it before.
142. I thank Detective Senior Constable Nathan Snell for his investigative work and the care he showed PE's family.
143. I thank Counsel Assisting Peita Ava Jones and her instructing solicitors Kathleen Campbell and Gulcan Shadiac from the Crown Solicitor's Office for their hard work preparing this inquest.
144. Finally, I once again offer my sincere condolences to PE's family for their profound loss. I thank them for attending and participating in this inquest.
145. I close this inquest.

Judge Harriet Grahame

Deputy State Coroner

1 May 2026

Coroners Court of NSW, Lidcombe