STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of MA
Hearing dates:	20 May 2019
Date of findings:	19 June 2019
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody, hanging point in cells, self-inflicted death
File numbers:	2016/273191
Representation:	Ms B Notley, (Sergeant) Coronial Advocate assisting Mr A Jobe, solicitor, Office of General Counsel for the Commissioner of Corrective Services NSW (CSNSW) Mr M Sterry, solicitor, Justice Health and Forensic Mental Health Network (JH&FMHN) Ms B Haider, solicitor (Nurses and Midwives Association) for Registered Nurses Aberra and Nolan Mr J Raftery, instructed by Mr Casimir for GEO Group Australia Pty Ltd Mr B Bradley, instructed by Ms Vivoda for MTC-Broadspectrum

Findings

Identity

The person who died was MA

Date of death

MA died on 11 September 2016

Place of death

MA died at Parklea Correctional Centre, Parklea, NSW.

Cause of death

MA died from hanging.

Manner of death

MA's death was intentionally self-inflicted.

Non-Publication orders

I order that there be no publication of the following material,

1. That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009 (NSW)*:
    a. The names, addresses, phone numbers and other personal information that might identify:
        i. Any member of MA's family;
        ii. Any person who visited MA while in custody (other than legal representatives or visitors acting in a professional capacity).
    b. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW').Initials may be used as pseudonyms in accordance with initials used in these findings.
    c. The Inmate Profile Document located at Tab 41 of the Brief of Evidence.
    d. CCTV footage and/or still images taken from CCTV.
    e. Information which may tend to identify the deceased in respect of the Inquest into the Death of 'P' to which findings were published on 10 November 2017.

f. The statements of Julie Ellis dated 1 May 2019 (together with the annexures to that statement) and 16 May 2019. (also contained at 319-410 of the brief), except as set out in these findings.

g. The following GEO policy material:

   i. OP043 – Medical Area;

   ii. Post Order POAR307 – Reception Correctional Officer;

   iii. OP096 – Reception Room Procedures; and

   iv. OP088 – Risk Intervention Team (RIT) Protocols for Inmates at Risk of Self Harm or Suicide.

2. Pursuant to section 65(4) of the *Coroners Act* 2009 (NSW), a notation be placed on the Court file that if an application is made under s.65(4) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

3. Pursuant to section 75 of the *Coroners Act* 2009 (NSW) I order that there be no publication of the name or identifying information of the deceased or his partner or members of his family. Initials may be used as pseudonyms in accordance with initials used in these findings.

4. Pursuant to section 75(5) of the *Coroners Act* 2009 (NSW) I permit publication of the information contained in these findings in accordance with the above restrictions.

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Introduction

1. MA was 44 years of age at the time of his death. He was at Parklea Correctional Centre in relation to a breach of parole and in relation to fresh charges which were pending. At the time of MA's death Parklea Correctional Centre was privately operated by the GEO Group Australia Pty Ltd (GEO), through a contractual agreement with the Commissioner of Corrective Services. Since 1 April 2019 the prison has been operated by MTC-Broadspectrum. The court was also advised that the primary medical care at the correctional centre which was provided through Justice Health & Forensic Mental Health Network (JH&FMHN) at the time of MA's death, is now be provided by St Vincent's Hospital Sydney Limited (SVHS).

2. Parklea Gaol is in metropolitan Sydney. The prison has a current capacity to house around 800 inmates. Once new facilities are completed on the site, the capacity will be greatly enlarged.

3. A revocation of parole warrant in relation to MA had been issued on 31 August 2016. On 8 September 2016 MA was arrested in relation to a number of serious domestic violence offences and he was taken to Belmont Police Station. The parole warrant was executed and bail was refused. MA's balance of parole was recorded as 4 months and 9 days.

4. Records indicate that after having been held briefly at Belmont Police Station, MA was received into custody at Parklea Correctional Centre on 9 September 2016.

5. After induction screening MA was housed in area 3A of Parklea Correctional Centre.

6. On 11 September 2016, not long after 7pm, MA was found by correctional officers hanging by a torn bed sheet, at the back of his cell. He was alone. He was cut down from the hanging position and CPR was commenced. Paramedics were called, but MA could not be revived. He was pronounced dead at 7.30pm.

7. A post mortem examination was conducted on 13 September 2016. The forensic pathologist conducting the examination confirmed that MA's death was caused by hanging. MA was later formally identified by his sister.

The role of the coroner

8. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future.[2]

9. In this case there is no dispute in relation to the identity of MA, or to the date, place or medical cause of his death. For this reason the inquest focused on the manner and circumstances surrounding his death. It was also necessary to consider whether or not his

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)

death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent similar tragedies occurring.

10. A finding that a death is self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention.[3] However, in this case the steps taken by MA, once he was alone, indicate a clear intention to take his own life.

11. Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner[4]. When a person is detained in custody the state is responsible for his or her safety and medical treatment. For this reason it is especially important to examine the circumstances of each death in custody and to understand how it occurred. Over the years there have been many hanging deaths in NSW correctional centres. There is a public interest in looking towards finding further ways to reduce this tragic statistic.

12. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of MA.

Scope of the inquest

13. A number of issues relevant to MA's death were identified prior to the inquest commencing. These issues included, among others, the lack of medication prescribed to MA given his known mental health history, the adequacy of information sharing between JH&FMHN and correctional officers, the decisions made around cell placement and the steps which have subsequently been taken to improve cell architecture at Parklea.

14. The inquest took place on 20 May 2019. A three volume brief was tendered including statements, recordings, prison and medical records. Four witnesses were called to give brief oral evidence.

Background

15. MA was born on 4 January 1972. He grew up on the Central Coast of NSW. He was the eldest of three siblings. In 1986 his family moved to Belmont, NSW. After school MA worked in the construction industry and had qualifications in scaffolding, rigging, and as a fork lift and train driver. At around 24 years of age he became involved with a woman who became his long term partner. They had two children together.

16. The family appear to have had many happy times. However in recent years the relationship was marred by violence and drug use. MA's partner attended the hearing, but did not wish to give evidence.

17. MA had a criminal record and had been in custody before. There appear to have been no recorded suicide attempts on his correctional or medical files.

[3] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.(*Briginshaw* v *Briginshaw* 60 CLR 336)
[4] See sections 23 and 27 Coroner's Act 2009 (NSW)

MA's reception into custody

18. On 9 September 2016, at about 9.54 pm Registered Nurse (RN) Ephrem Aberra conducted a Reception Screening Assessment (RSA) on MA. The document produced notes that as part of this routine screening process, MA disclosed that he had a history of mental health issues, namely depression and that he was prescribed Escitalopram in the community. MA disclosed that he used methamphetamines (ice) on a daily basis and had last used it "one week ago."[5] A "Kessler 10" test was apparently administered. RN Aberra noted the score as 12/50, indicating that at that time MA was "not experiencing significant feelings of distress."[6] Although MA stated that he was concerned about his mental health issues, RN Aberra also indicated that MA said that he would "cope well in prison". Given the low Kessler score, RN Aberra considered no immediate action was warranted.

19. RN Aberra states that he would then have created a Request for Information(ROI) form to obtain treatment and medication information from MA's community health care providers for future collection. He also made a referral in the Patient Administration System (PAS) for MA to be placed on the waiting list to be reviewed by the Adult Ambulatory Mental Health Team and the Drug and Alcohol Team. At the time of collecting the initial information, RN Aberra stated that he had access to limited information[7] as the inmate's previous files would have been held elsewhere and it was not RN Aberra's usual practise to request them at the time of the initial screening.

20. RN Aberra was also tasked to complete the Health Problem Notification Form (HPNF)[8]. This document is the main conduit of health information from JH&FMHN to correctional officers and is used to assist in the making of cell placement decisions. This form appears to have been auto-filled as having been completed at 9.51pm, that is prior to the RSA. There is no explanation for this discrepancy. The information on the form is extremely brief. "Normal Cell Placement" is recommended. This designation could mean MA was housed by himself or with another inmate(s) in a normal cell.

21. The section of the HNPF which is used to alert correctional officers to signs or symptoms that should be reported to JH&FMHN staff adds little valuable information. It states "New reception – previous experience/Hx Mental Health condition/Guarantees own safety." In other words, there is nothing to alert correctional staff to the possibility of suicidal ideation or any particular issue to watch out for. RN Aberra gave evidence at the hearing. Unsurprisingly, after the time which has now elapsed, he had no independent memory of the brief assessment process he had conducted with MA and was thus unable to expand further on his initial impression of MA.

22. RN Aberra was questioned briefly on the question of ice withdrawal. He had noted on MA's form that MA's last ice use was a week ago. RN Aberra did not appear to be worried about the potential effect of that. He stated "Technically, there's no withdrawal from ice. Once they're off it for a week there shouldn't be - there's no, as such, withdrawal. There might be - often then they might feel distressed for a little while but it is not as bad as the other drugs we normally use – where we use withdrawal management."[9]

[5] RSA, exhibit 1, page 449
[6] Statement of RN Aberra, Exhibit 1, page 450 [11]
[7] Evidence of RN Aberra 20/5/19 page 13, line 15 onwards
[8] This document appears in the Exhibit 1, page 322
[9] Evidence of RN Aberra 20/5/19 page 13, line 14 onwards

23. It is impossible to know why MA told his cellmate that he had been using consistently for 13 days and yet he apparently told RN Aberra that he had last used a week previously. Whatever the reason, the information recorded by Nurse Aberra did not ring any particular alarms bells. In my view it is likely that MA's use was heavier and more recent that RN Aberra realised. The behaviour outlined in his recent charge sheet indicates that it is likely MA had been on an ice binge, prior to his entry into custody. When questioned RN Aberra felt confident that he had sufficient training in relation to drug and alcohol issues, however it may be that front line medical staff should receive further training in relation to the potential mood effects of ice withdrawal. Anecdotal evidence now suggests high levels of ice use in persons entering custody. It may be that reception staff should be encouraged to be more curious in relation to the possible effects of sudden amphetamine withdrawal, particularly in patients with known mental health issues such as depression.

MA's medication

24. RN Aberra recorded that MA had been taking an oral dose of Escitalopram (20mg) daily. It appears that he did not have the medication or prescription on him. To receive medication in custody, a patient must be prescribed that medication by a GP or psychiatrist in the correctional centre. In this case RN Aberra did not see any urgent or compelling reason to depart from the normal practise which was to record MA's usual medication and place him on the mental health list to be seen by a psychiatrist who could assess him and if necessary continue the prescription. RN Aberra appears to have understood this may have taken some time. However he stated that if MA had been looking "very unwell" he would have kept him in the clinic and created a HPNF which would keep him in there until he could be cleared by the Mental Health Team or a GP. During the short time MA was in custody he did not receive his medication.[10] There was no evidence before me to indicate whether he had been compliant in the community or what the effect of ceasing his medication may have been.

MA's cell placement

25. After screening by JH&FMHN staff, an inmate is reviewed by a reception officer. Notwithstanding that a JH&FMHN nurse has recommended normal cell placement, a correctional officer may nevertheless decide that further review should take place. If, for example a correctional officer observes worrying or "abnormal" behaviour then the officer can place the inmate on a Mandatory Notification Form (MNF) which is then reviewed by the Centre's Risk Intervention Team (RIT). This process is known as "placing an inmate on a RIT."[11] The court was told that on 9 September 2016, Correctional Officer Derrick Brown reviewed the HPNF prepared by RN Aberra in relation to MA. On the basis of information available to him, Mr Brown recorded that MA should be given "normal cell placement". This designation meant that he could be placed with or without a cellmate and would be housed in a "normal cell." This is sometimes called a "white card." Inmates on a "green card" must only be placed with another inmate and cannot be left alone for any length of time.

[10] Statement of RN Nolan, Exhibit 1, page 467
[11] This process is outlined in the statement of Derrick Brown, Exhibit 1, Volume 2, page 323

26. It is clear from the statement provided by Correctional Officer Brown that he misunderstood the nature of the decision he was called upon to make when he placed the inmate. He states "the placement of inmates as either one-out or two-out cell is the decision of Justice Health staff."[12] This is incorrect and although correctional officers will properly take into account information recorded in the HPNF, decisions relating to cell placement rest with the correctional officer.

27. MA was placed in area 3A with a cellmate, SW. SW said that MA had been honest about assaults he had recently committed on his partner and spoke candidly of the breakdown of their relationship. MA was reportedly heartbroken about missing his children, whom he loved dearly. SW told the investigation that MA admitted that he had smoked ice for 13 days straight following his release from custody on the last occasion. He had not slept during that time. SW explained that MA was exhibiting withdrawal symptoms and that since arriving had slept all day and night. While he understood that MA was distressed about the long sentence he may be facing, SW stated that he did not realise that MA was suicidal. On the contrary he stated that MA appeared "in good spirits" when SW left for medical treatment on the afternoon of MA's death. In SW's view "it was the drugs that done that."[13]

28. Photographs tendered in these proceedings show that MA's cell had numerous potential hanging points, including but not limited to the bars to which he ultimately attached his bed linen.

The evening of 11 September 2016

29. MA and his cell mate were provided with their evening meal around 2.30pm. According to his cell mate SW, MA ate his meal, then showered and shaved. About 3pm the centre was placed in lock down and a final bed count was conducted according to normal routine.

30. A short time later SW smoked a nicotine patch. SW was asthmatic and the patch triggered an asthma attack about 4.20pm. MA used the cell intercom to call correctional officers to inform them that SW was having chest pains. At 4.22pm Correctional Officers and Justice Health staff attended the cell and transferred SW to the medical clinic for observation and treatment. Prior to removing SW they confirmed that MA had a "white card" which meant that he could be left alone.

31. Later that evening it appears that SW was well enough to return to his cell. At 7.09pm correctional officers Aimee Flynn and James McCarthy returned SW to his cell. As they opened the door they saw that MA was hanging towards the back of the cell with his face to the wall. He appeared suspended by a torn bed sheet. SW was removed from the area and a CERT call was initiated. Officers cut MA down using a "911" tool and lay him on the floor to commence CPR. He was taken outside the cell, where there was more space and assisted by officers until paramedics arrived at 7.26pm. He was pronounced dead, four minutes later.

[12] Statement of Derrick Brown, exhibit 1, page 325 (xviii)
[13] Transcript of ERISP with SW, page 4

What steps have been taken at Parklea Correctional Centre to remove or reduce the risk of inmates hanging themselves?

32. One of the tragedies of MA's death is that it is not an isolated incident. Hanging points are a longstanding and well recognised problem in the custodial environment. As a result of coronial recommendations back in 2010,[14] Corrective Services NSW (CSNSW) conducted a state-wide survey and audit of the Corrective Services estate for obvious hanging points and "high risk" furniture installations. This resulted in some positive change in relation to "step down cells" in a variety of NSW Gaols, not including Parklea. More recently there have also been some attempts to address suicide mitigation strategies at Parklea Correctional Centre.

33. A review by GEO in 2017 resulted in the document "Action Plan – vulnerable Inmate and Suicide Protection Strategies"[15] The stated objectives of that review were to identify the most appropriate and cost effective ways to significantly reduce and eliminate hanging points in Parklea's normal placement cells and to implement a funded project to remove obvious hanging points identified in Parklea's normal cell placement. Some of the strategies included removal of fixtures such as shower curtain railings, metal louvres fitted to windows above cell doors and metal bars anchoring shelving units to walls. The plan required the cooperation of CSNSW. The work recommended in 2017 was largely completed but represented a "partial fix".

34. One of the initiatives was to increase the number of "step down" cells. These cells have reduced hanging points. These additional cells have increased the capacity to transition inmates from safe cells to normal discipline in a more staged approach that is consistent with a policy of least restrictive care but which provides some additional safety for inmates. Other initiatives relate to architectural and furniture changes in some cells, and changes in relation to screening policies for fresh inmates.

35. In October 2018 CSNSW arranged for Perumal Pedavoli Architects (PPA) to conduct a high-level review of areas 1, 2 and 3 of Parklea Correctional Centre to identify risk issues in normal placement cells. The preliminary report entitled "Review of Ligature Points in Existing Cells – Areas 1, 2 & 3"[16] was produced. A wide range of fittings were reviewed including bunk beds, cell windows, cell desks, door handles, wash basins and light fittings. However, the authors cautioned that looking at individual fittings in isolation from the remainder of the cell environment "would not result in a safer cell." A "whole of cell" design solution was needed.

36. The report states "the design of the furniture in the Parklea cells does not lend itself to any form of rectification that would eliminate all ligature risks. Each cell type differs due to retro fitted items installed over the life of the prison. Some issues are simply not able to be fixed without replacement. The cell furniture should be removed and replaced with custom built items designed to current standard."[17] The report concluded that further work was needed to address the identified risks at a more specific level.

37. The court was provided with a statement from Julie Ellis, Director of Corrective Services Governance and Continuance Improvement Division. Ms Ellis also gave oral evidence. She

[14] Inquests into the deaths of Desmond Walsley and Manoa Tupou.
[15] See annexure 1 to the statement of Julie Ellis (1/5/19) Exhibit 1, Volume 3
[16] See annexure 2 to the statement of Julie Ellis (1/5/19) Exhibit 1, Volume 3
[17] Statement of Julie Ellis (1/5/19) Exhibit 1, Volume 3

stated that there has been no decision to commission any further consultants to address the issues raised in the PPA report. She stated "it may be that, as is foreshadowed in the report's conclusion, a whole of cell design solution might prove more expensive by way of retrofitting than building a new facility. In either case, there are clear budgetary implications surpassing the financial capacity of CSNSW and/or the new operator and whose solutions would require government commitment and budgetary support."[18]

38. While some changes have been made to some cells at Parklea, the cell MA died in and others in that area, remain unsafe with known hanging points. There appears to be no plan to rectify that situation and no government commitment to make implementation of such a plan possible.

The need for recommendations

39. I have carefully considered the need for recommendations in this matter. The problem lies with the fact that we are imprisoning people in cells which are known to be unsafe and unsatisfactory. A cost analysis decision appears to have been made that it is just too expensive to remodel every unsafe cell in this state. There is an acceptance at a departmental level that comprehensive change is currently unfeasible. It is in my view entirely unacceptable, however I am sceptical that any recommendation I make will change this regrettable situation. Given the known architectural risks are not being tackled, more must be done to increase other protective strategies.

40. I note that the contract between CSNSW and MTC-Broadspectrum has been written to provide penalty for unnatural deaths.[19] One hopes this adds additional commercial pressure to the new operator to avoid unsafe cell allocation.

41. On a review of the evidence, I remain concerned about the possible missed opportunity that occurred on MA's reception. His cellmate reported that MA had just ceased a major "ice binge". For reasons which remain unclear this information was not obtained during MA's initial health screening. I wonder whether it is time to review the training given to induction nurses in relation to the potential mental and mood effects of ceasing amphetamines after heavy use, particularly in an inmate with a known history of depression. However, there appears little utility in making recommendations to GEO, who no longer operate the prison. MTC-Broadspectrum indicated that its medical services at Parklea will be run by a new provider, SVHS. For this reason, I have decided not to make a formal recommendation in this regard, but given the cooperation MTC-Broadspectrum has shown during the inquest, I request that MTC-Broadspectrum considers alerting its health provider, SVHS to this issue by providing a copy of these findings to it for review.

42. The other area where a recommendation was considered involved introducing formal protocols to mitigate the risk of placing people with documented mental health histories *alone* in cells known to provide hanging points, prior to a full mental health assessment. CSNSW indicated that recent changes mean that there are now more cells in Areas 1 and 2 where such prisoners could be placed. These cells have been modified to reduce obvious hanging

[18] Statement of Julie Ellis (1/5/19) Exhibit 1, Volume 3 [32]
[19] Statement of Julie Ellis (1/5/19) Exhibit 1, Volume 3 [25]

points. This may assist some inmates. The need to consider placing those at possible risk in two-out cells must also be considered. While each cell placement decision must be considered individually, one cannot help but wonder if MA had been placed two-out, at least until he had been screened by a mental health practitioner, he would be alive today. It is certainly clear his suicidal action did not commence until he was left alone.

43. It is well known that the decision to kill oneself can be sudden and impulsive. I accept it is difficult to predict and I note that neither RN Aberra who screened MA, nor his cell mate thought MA was suicidal. In the gaol environment there are many documented cases of prisoners making this decision when left alone, even for short periods of time.[20] There is a well-known protective value in housing prisoners with a compatible cell mate.[21] With hindsight, MA should have been housed with another inmate in a two-out placement at least until he had been reviewed by a mental health practitioner and re-commenced on medication.

44. I am aware the Magistrate Elizabeth Ryan recently made a recommendation in the *Inquest into the death of L*[22] aimed at exploring options for obtaining tear resistant sheets for inmates in normal cell placement. I support that recommendation.

45. The safety issues at Parklea remain. It appears that CSNSW has no current intention or ability to provide the financial backing necessary to alter cells in Area 3, where MA died. MTC-Broadspectrum and SVHS need to manage the suicide risk, as best they can, by careful mental health screening and cell placement decisions. In my view the architecture remains unsatisfactory, with little chance for rectification in the short term. While I make no formal recommendations to the new providers, I hope they will carefully review these findings in a genuine attempt to develop strategies and policies which may create a safer environment for vulnerable prisoners in this troubling context.

Conclusion

46. MA's tragic death was unforeseen by those entrusted with his care. I accept that his decision to take his own life was likely to have been both sudden and unexpected. Once alone, he appears to have fallen into a state of profound despair. However he was placed in a cell that offered numerous hanging points. Had he not been able to attach his torn bed sheet to a hanging point in his cell, he may have survived until his cell mate returned. Equally, had he been placed "two-out" until he was seen by a psychiatrist, he may also have been somewhat protected. MA is not the only prisoner to have died in these circumstances.

47. Finally I offer my sincere condolences to MA's family and friends. His despair in custody is a tragedy and I acknowledge their grief and loss. I strongly urge that any published report of this death include reference to suicide prevention contact points.

48. I close this inquest.

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[20] See for example, *Inquest into the death of P*, 10 November 2017

[21] It is acknowledged that care must be taken when housing inmates who may have a propensity to violence or paranoia.

[22] *Inquest into the death of L*, 30 April 2019

Findings

49. The findings I make under section 81(1) of the Act are:

Identity
The person who died was MA

Date of death
MA died on 11 September 2016

Place of death
MA died at Parklea Correctional Centre, Parklea, NSW.

Cause of death
MA died from hanging.

Manner of death
MA's death was intentionally self-inflicted.

Magistrate Harriet Grahame
Deputy State Coroner
19 June 2019
NSW State Coroner's Court, Lidcombe