STATE CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of **AJ**
Hearing dates:	28, 29 July 2015
Date of findings:	11 August 2015
Place of findings:	Coroners Court, Glebe, NSW
Findings of:	Magistrate C. Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW-Cause and manner of death-death in custody-recommendations-inmates referred for mental health review-inmates who fail to attend for antipsychotic medication
File number:	2013/153360
Representation:	Mr S Kelly, Advocate Assisting Mr S Griffiths representing Corrective Services NSW Mr S. Woods representing Justice Health and the Forensic Mental Health Network
Findings:	I find that AJ died on 17 May 2013 at Prince of Wales Hospital, NSW. I am satisfied the cause of his death was hanging. The manner of his death was intentionally self-inflicted.

Recommendations:	*To the Minister for Health:* 1. I recommend that Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see the Justice Health Mental Health Team be rescheduled at the new Correctional Centre. 2. I recommend that the Drugs and Therapeutic Committee of Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider: (b) Reviewing the current procedures as set out in 6.6.1of the Medication Guidelines. (b) Training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines.

NOTE: PURSUANT TO S 75 OF THE CORONERS ACT 2009 I DIRECT THAT THERE BE NO PUBLICATION OF ANY MATERIAL THAT IDENTIFIES THE DECEASED PERSON OR HIS FAMILY

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

INTRODUCTION

1. This inquest concerns the sad death of AJ. He was a 19 year old man who was an inmate at Long Bay Correctional Centre. He is a much loved son and brother and his family have asked for him to be referred to by his first name.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

   Section 82 of the *Act* also permits a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with a death that relates to issues of public health and safety.

3. AJ's death was reported because it occurred while he was in custody. In these circumstances an inquest is mandatory pursuant to the combined operation of ss. 27 and 23 of the Coroners Act 2009.

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of a death…in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant*

department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[1]

4. Pursuant to s.37 of the *Coroner's Act 2009* a summary of the details of this case will be reported to Parliament.

AJ

5. AJ was born in 1993 and had an older sister, known as M, and step siblings known as T, N, J and R .His natural father passed away in April 2014.

6. As a child AJ and M grew up in Currabubla. According to M, the children pretty much looked after themselves.

5. In 2002 an application was filed by the Department of Community Services for parental responsibility for AJ and his siblings to be transferred to the Minister. This application was based on a number of reports to the Department surrounding mental health issues associated AJ's mother who had been diagnosed with schizophrenia, manic depression and anxiety.[2]

6. The children were placed in foster care in Queensland. After approximately 2-3 years they returned to live with their father in Boronia Heights with weekly supervision from Life Without Barriers and the children remained under the parental responsibility of the Minister.

7. In 2008 the Department became aware that AJ had begun to exhibit out of control behaviours, acting out, fighting at school and had disclosed verbal and emotional abuse occurring at the home by his father. This information was also confirmed by one of his siblings who stated that after returning home, AJ began to miss school. Eventually he was expelled from the local school for assaulting another student and attended three different High Schools before completing year 10.

8. In 2007 AJ and M left their father's and moved to Port Macquarie to live with their mother.

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[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

[2] Ex 1, Vol 2, Tab 48

9. In February 2013 he was sentenced for a number of offences and on 13 Feb 2013 when he arrived at the Mid North Coast Correctional Centre he was assessed by Justice Health Nurse Anthony McMahon.

10. During his reception screening he informed Mr McMahon that he had been diagnosed with schizophrenia requiring Seroquel medication, 100mg in the morning and 200mg at night. AJ completed a "Kessler 10". This tool is used to measure the current level (last four weeks) of stress, anxiety and depression. AJ received a score of 10 / 50 which indicated that he may not be experiencing any significant levels of distress at the time he completed the test.[3] AJ also denied any previous attempts of suicide or self-harm.

11. Mr McMahon said that at the end of the screening he completed a summary of his findings and found that AJ was a young offender with previous gaol experience that he presented as calm and relaxed that he had a possible diagnosis of schizophrenia treated with Seroquel and he contacted Justice Health Medical Records to obtain scripts. He also said he created a referral on Patient Alert System to the Mental Health Nurse for follow up and management.

12. AJ was placed on an appointment list at the Mid North Coast Correctional Complex for review for 9 March, 26 March, 29 March and 1 April 2013 however he did not attend those appointments as he was moved to the Grafton Correctional Centre on 18 Feb 2013. He was not placed on the waiting list for the Mental Health Team at Grafton after he was transferred.

13. On 4th April 2013 AJ was transferred to Long Bay Correctional Centre. Once again he was not placed on the waiting list for a Mental Health follow up.

14. On 7th April AJ was assigned Bakery duties. AJ's duties included 6.30am weekday starts working in the flour mixing area.

15. On the 8th May 2013 AJ was interviewed by Senior Correctional Officer Craig Creighton and Correctional Officer Clarke in relation to a proposed DNA test to be obtained from him. This procedure was planned in accordance with the Crimes Forensic Procedure Act NSW 2000. During this meeting AJ was reported to be calm and happy. According to Mr Creighton, AJ did not raise any problems or issues associated with the taking of his DNA. He signed the pre interview form willingly and was provided with an information pamphlet.[4]

[3] Ex 1, Vol 2, Tab 51 para 7.
[4] Vol 1, Tab 10, para 7.

CIRCUMSTANCES OF DEATH

16. About 4.30am on 15 May 2013 AJ's cellmate was released from his cell by the night watch officer so he could attend for Bakery duties.

17. About 6.00am Mr Mark Yates and Correctional Officer Pravat Dash attended AJ's Wing to collect a number of inmates, including AJ, for bakery duties. AJ informed Correctional Officer Dash that he was sick that morning and couldn't attend. Correctional Officer Dash informed AJ he would pass the information on and advised AJ that if he required any medical attention to let him know. AJ replied that he would attend the morning clinic. (Corrective Services notes record that at around this time AJ had been showing a lack of interest in his bakery duties and on the 2 May 2013 he was counselled and warned. On the 13th May 2013 he was given one more lifeline.)

18. At about 7.10am muster was called by Correctional Officer's Izard, Warren, Kaur and Assistant Superintendent Michael Frawley. All inmates were accounted for and checked against the muster book and the cell card.

19. AJ was due to have his DNA obtained. At about 8.20am, Correctional Officer Debra Po'oi asked for AJ who was the first name on the list to have his DNA obtained.

20. One of the inmates, Mr Butler, approached AJ's cell and noticed the door was closed but not locked. Mr Butler opened the door and observed the cell was dark. He looked in and saw someone who appeared to be standing on a chair near the window. It took a few seconds for his eyes to adjust before he could see. He then yelled out to AJ but when he did not respond he took three steps into the cell and noticed a ligature of green cell sheeting around AJ's neck which was tied to the metal grill on the outer window cavity. He could see AJ's skin and his lips were blue. He immediately exited the cell and told another inmate to not let anyone into the cell as it was now a crime scene. That inmate tried to undo the knots that were around AJ's neck.

21. Correctional officer Izzard entered the cell and cut the bed sheet with a 911 tool. AJ was moved to a clear area where CPR was commenced. Shortly after Correctional Officer Po'oi attended and radioed for urgent assistance. Officer Po'oi lent down and checked for AJ's radial pulse and for a femoral pulse but was not able to locate one. Senior Assistant Superintendent Dino Krizman attended the scene and took charge of the CPR duties and the management of the scene. A time log was commenced at about 8.35am by Correctional Officer Warren. At

this time Correctional Officer Po'oi was instructed to search the cell for any form of suicide note which she did but none was found.

22. Justice Health personnel attended and took over resuscitation duties. The medical team was led by Dr Mica Apasojeviv until the arrival of paramedics at 8.46am.

23. At 9.08am AJ was removed from the cell was taken by Ambulance to Prince of Wales Hospital in a critical condition.

24. He was admitted into the Intensive Care Unit where he was continually monitored. A CT examination revealed that he sustained global ischemic brain injury. AJ deteriorated and with family consultation the medical team made a decision to cease further medical treatment. AJ passed away at about 2.30am on 17th May 2013.

CAUSE OF DEATH

25. On that same date a limited Post Mortem was conducted by Dr Brouwer who determined that the ligature mark present on his neck was in keeping with that caused by the torn strips of material. Dr Brouwer recorded the cause of AJ's death as *"in keeping with the consequences of hanging."*

MANNER OF DEATH

26. There were seven occasions from the beginning of April 2013 up to an including 14 May 2013 when AJ did not attend the clinic to pick up his medication.[5]

27. AJ last attended to receive his medication on the 12 May 2013.

28. Paragraph 6.6.1 of the Justice Health and Forensic Mental Health Network Medication Guidelines states

> *"Any patient who has been prescribed antipsychotic or antidepressant medication and who does not attend must be followed up immediately. If the patient refuses to take the medication once contact is made, the patient must be seen by the treating psychiatrist at the earliest opportunity. There should be daily contact with the patient until the psychiatrist sees them. This should be used as an opportunity to educate the patient regarding the need for medication and to gain an understanding*

[5] Ex 1, Vol 1, Tab 46

of why the patient does not wish to continue the medication. This is particularly important for patients prescribed antidepressant and antipsychotic medication."

29. This guideline was not complied with in relation to AJ's non attendances for his medication. He was not followed up after any of his non attendances, he was not educated regarding the need for his medication, there was no attempt made to understand why he did not wish to continue his medication and not only was he not seen by his "*treating psychiatrist*" but no arrangements were made for that to occur. In fact he didn't even have a "*treating psychiatrist*" as he had never been seen by the Mental Health Team since he arrived in custody three months earlier.

30. The evidence suggests that this guideline is not complied with in the normal procedure at the clinic. Evidence showed that the normal procedure for when a patient does not attend to pick up their medications would be to page them over the loud speaker to attend the clinic to collect their medication. If they did not attend, a referral was made on the Patient Administration System (PAS) to refer them to Mental Health Nurse waiting list.

31. In AJ's case this was not done supposedly because he was already on the PAS waiting list system from February 2013 when he first entered custody.

32. It is striking that not only is the guideline ignored but that attempts are not made to locate the patient with the assistance of Corrective Services and furthermore that Corrective Services are not notified that an inmate is not taking his antipsychotic medication.

33. In AJ's case there is no evidence that his non-attendance to collect his medication caused or contributed to his decision to take his own life. There is no evidence his mood, behaviour or demeanour had changed.

34. There were no signs that AJ was contemplating intentional self-harm.

35. AJ's cell mate was interviewed in relation to AJ's death. He stated that he got along well with AJ who was generally in a happy mood and seemed to get along with everyone. He said AJ did not mention any issues and talked about an extradition to Queensland when his sentence had expired in NSW but was not worried about it. He said he saw AJ when he was woken to go to Bakery duties the morning of the 15th May 2013 and he was still sleeping on the bottom bunk. A second inmate was also spoken to and confirmed that AJ had not mentioned any concerns or worries to him when he last spoke to him on the 14th May 2013.

36. AJ's father provided an audio statement to Investigators. He advised that AJ had never spoken to him of any issues he was having in jail and he believed AJ was looking forward to getting out in the near future. He did not believe that AJ was worried about returning to Queensland to face any other outstanding matters or provide his DNA. According to his father, AJ had never previously discussed killing himself or committing self-harm.

37. An investigation was also conducted by Mr Farrell from Corrective Services. He noted that:

- on 8 May 2013 AJ was interviewed regarding his post release plans by the Community Offenders Services and Programs Section who recorded that 'The offender appeared positive and was more than happy to discuss his post release accommodation plans and goals'.

- on 9 May 2013 AJ was seen by Case Officer Widge who stated that AJ appeared calm and not depressed and expressed interest in being referred to a Psychologist for an appropriate course to address *'his offending behaviour'*.

- on 10 May 2013 AJ was also interviewed by a Welfare Officer who stated that inmate AJ presented as *'future orientated, made good eye contact and nil other issues were raised'*.

- on that same date AJ had been seen by a Services and Programs Officer who discussed his participation in an upcoming program called Getting SMART. The file note states that he completed a pre-program interview and stated he is willing to participate in all 12 sessions of the program.

38. The evidence does not allow me to make a finding as to why AJ took his own life but it is clear that there were no suspicious circumstances and that his death was intentionally self-inflicted.

39. I accept Counsel Assisting's submissions that Corrective Services responded appropriately on the day AJ was found hanging and that the subsequent investigation was appropriate.

CONCLUSION

40. AJ's death highlighted shortcomings in relation to compliance with Justice Health's own guidelines and policies. Firstly, despite being referred by Justice Health Nurse McMahon in February 2013, when AJ entered custody, to be reviewed by a mental health clinician this never occurred during the whole time he was in custody. Although he was initially given appointments and on a waiting list in February 2013 at the Mid North Coast Correctional Centre, once he was transferred he did not have any appointments scheduled and he was never seen by the Mental Health Team. The medication and dosage he was receiving was as a result of his own request and he was never assessed as to its appropriateness.

41. Secondly, the only people that knew he had not attended for his medication on the seven occasions in April and May 2013 at Long Bay Correctional Centre were the nurses that were dispensing the medication. This was not only in breach of the concerns set out in the guidelines but also highlights the lack of communication with Corrective Services who would have been able to assist in locating AJ and also could have been on high alert for any change in his demeanour.

42. I note that Justice Health and Forensic Mental Health Network and Corrective Services acknowledge the importance of these shortcomings and are willing to implement changes that will ensure this situation is not repeated. I propose to make recommendations that address these issues.

FORMAL FINDINGS

I find that AJ died on 17 May 2013 at Prince of Wales Hospital, NSW. I am satisfied the cause of his death was hanging. The manner of his death was intentionally self-inflicted.

RECOMMENDATIONS

To the Minister for Health:

1. I recommend that Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see the Justice Health Mental Health Team be rescheduled at the new Correctional Centre.

2. I recommend that the Drugs and Therapeutic Committee of Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider:

   (a) reviewing the current procedures as set out in 6.6.1of the Medication Guidelines.

   (b) training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines.

   (c) reviewing communication between Justice Health and Corrective Services on issues relating to an inmate's non-attendance for antipsychotic medication.

C.Forbes
Deputy State Coroner
11 August 2015