CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of L
Hearing dates:	18 – 21 February 2019
Date of findings:	30 April 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody – Parklea Correctional Centre - what was cause of death – was mental health care provided by the GEO Group Pty Ltd, Justice Health and Corrective Services NSW adequate – measures to reduce suicide risks.
File number:	2016/214323
Representation:	Counsel Assisting the inquest: S Palaniappan of Counsel i/b NSW Crown Solicitor. The L family: H Cooper, Legal Aid NSW. Justice Health and Forensic Mental Health Network: B Bradley of Counsel i/b Makinson d'Apice Lawyers. Corrective Services NSW: R Graycar of Counsel i/b Office of the General Counsel, NSW Department of Justice GEO Group Australia Pty Ltd: J Raftery of Counsel. RN R Osbourne: H Toose, NSW Nurses and Midwives Association.

Findings:	**Identity** The person who died is L. **Date of death**: L died on 14 July 2016. **Place of death**: L died in his cell at Parklea Correctional Centre, Quakers Hill NSW. **Cause of death:** L died as a result of asphyxiation by ligature. **Manner of death:** L's death was intentional and self-inflicted, in circumstances where he was an inmate at Parklea Correctional Centre.
Recommendations:	- To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that consideration be given to reviewing the method by which inmates are called to a Clinic appointment by announcement over the PA system, and that other options be explored as additions or alternatives. - To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that options for obtaining tear resistant sheets for inmates in normal cell placement be explored and costed as an alternative to the normal bedding issued to inmates.

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Non-Publication Orders

Pursuant to section 75(2)(b) of the *Coroners Act 2009 (NSW)* I order that there be no publication of the name or identifying information of the deceased, his spouse, their children, his mother and his sister. Initials may be used as pseudonyms.

Pursuant to section 74(2)(b) of the *Coroners Act 2009 (NSW)* I order there be no publication of the letter dated 8 March 2019 from Mr V Musico Senior Solicitor, Office of the General Counsel, to Ms C Skinner, Senior Solicitor, Crown Solicitor's Office, and its attachment of eleven photographs.

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.

Introduction

Section 81(1) of the *Coroners Act 2009* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of L.

1. On 14 July 2016 L aged 43 years died at Parklea Correctional Centre. L was on remand awaiting trial on criminal charges. As L was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act an inquest is required when a person dies in custody, to assess whether the State has discharged its responsibilities.

The role of the Coroner

2. Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

3. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

L's life

4. L was born on 30 January 1973 to parents EAP and CG. He had two older sisters, W and C, and the family lived in a farm house 30 kilometres from Grafton NSW. When L was only 14 years of age his father died, and L left school to get a job.

5. In 1999 L married A, whom he had met through the sport of archery. The couple lived in Grafton and had two children. L worked in the telecommunications industry and A in accounts management.

6. On 25 September 2015 L entered custody awaiting trial on criminal charges, and died there ten months later. Each day of this inquest was attended by L's wife A supported by her own mother, and L's mother and his sister W.

7. At the close of the evidence they all spoke lovingly of L and it is clear they grieve his loss deeply. They told the court of his generosity as a son, husband and brother and of the love and pride he took in his own children and those of his sisters. In particular it saddens his family to think that L died alone, separated from them.

L's custodial history

8. On 25 September 2015 L was charged with multiple offences of aggravated sexual and indecent assault of girls under 16 years of age. He was refused bail and was incarcerated in Grafton Correctional Centre. The following

month he was moved to Cessnock Correctional Centre, and then on 5 November 2015 to Parklea Correctional Centre [Parklea] which is located in metropolitan Sydney. At his own request L was being held in Special Management Area Placement due to the nature of his charges. A Supreme Court bail review hearing had been listed for 2 August 2016.

9. This was the second time L had been charged with child sex-related offences. In 2014 he was charged with offences of possessing child abuse material, indecent assault, and firearms offences. He received a sentence of fifteen months imprisonment and was released to parole in June 2015. Three months later he was charged with the further offences referred to above. The court heard that a trial for the new charges was listed for February 2017.

10. L's wife A reported that soon after being charged in 2014 L began to suffer depression and anxiety. His conditions of depression and anxiety did not resolve over his remaining two years, and they played a major part in his death.

Parklea Correctional Centre

11. From 2009 until 1 April 2019 2009 Parklea was operated by GEO Group Australia Pty Ltd [GEO Group] through a contractual agreement with the NSW Commissioner of Corrective Services. Its operation remained under the oversight of the Commissioner of Corrective Services. The prison has capacity to house up to 800 inmates, a large proportion of whom are on remand awaiting the outcome of criminal charges. Health and psychiatric services for the Parklea inmates are provided by the Justice Health and Forensic Mental Health Network [JHFMHN]; however psychology services for inmates were provided by GEO Group.

12. Changes to Parklea are forthcoming. First, on 1 April 2019 the operation of Parklea transferred to a new private consortium, MTC/Broadspectrum. Secondly, a new facility is being built and is planned to be in operation by the end of 2019. This will increase Parklea's total inmate population to 1,300. The proposed fit out of the cells in the new facility is of relevance to this inquest and is addressed later in these findings.

13. Parklea was described by a number of witnesses at the inquest as an aging correctional facility, constructed almost 40 years ago. Its inmates are housed in five areas of the jail. L's cell was in Area 2 which could accommodate up to 123 inmates. Area 2 inmates are held in various forms of protective custody and are not able to mix with inmates from the other areas of the jail.

14. At the time of his death L was housed in a cell with another inmate, GJ. L and GJ had shared this cell for approximately four months. They appeared to have a good relationship and often spoke to each other about their families. Their cell was fitted with a double deck bunk bed, with the uppermost bed occupied by L.

The events of 14 July 2016

15. On 14 July 2016 L's cell mate GJ was absent from Parklea due to a court commitment, and did not return until later that night. Throughout the day L made a number of phone calls to his wife A. At about 2.15pm he told her he felt depressed and upset that she had formed a new relationship. A tried to reassure him of her support and said she would talk to him the next day, but L told her he was saying goodbye. In accordance with usual routine L was locked into his cell at about 3.15pm.

16. At 8.50pm two correctional officers escorted GJ back to his cell in Area 2A. GJ entered the cell first and immediately cried out '*Oh, no, no, no'.* The correctional officers followed and saw L hanging from the railing of the top bunk, with his knees almost touching the floor. He had torn lengths from his green bed sheets and plaited them together to fashion a rope. This he had looped three times around his neck and attached to the upper bed railing.

17. Correctional Officer SL immediately called an alarm. He and his fellow officer then checked L for vital signs but could find none. L's body was limp and cold and he had no pulse. The officers cut the sheet-rope and placed L on the cell floor. When emergency nurses and paramedics arrived a few minutes later they too could find no signs of life. L was pronounced deceased.

18. The post mortem report of forensic pathologist Dr Istvan Szentmariay confirmed that L had died as a result of hanging.

L's psychiatric history in custody

19. A primary focus of the inquest was the mental health care and treatment L received while in custody at Parklea.

20. It is well documented that prison inmates suffer a disproportionate amount of psychiatric disorder. In addition according to expert psychiatrist Dr Olav Nielssen, who gave evidence at the inquest, almost a quarter of prisoners report symptoms amounting to a diagnosis of a depressive illness or anxiety disorder.

21. The evidence indicated that L's mental health difficulties started in 2014 when he was charged with criminal offences. He was commenced on the anti depressant citalopram. During his first incarceration he was found to have a '*potentially severe anxiety disorder and/or depression',* and his citalopram medication was continued. To Justice Health clinicians he denied having any current plans to harm himself or to take his own life.

22. When L re-entered custody in September 2015 he was assessed as needing ongoing psychological and psychiatric care. It was considered however that he presented *'low risk of self harm'*. By this time L was being prescribed the medication quetiapine in addition to his citalopram, to help with persistent sleeping difficulties. He had meetings with psychologists and nursing staff in October, November and December 2015 who recorded his symptoms of

anxiety, depression, poor sleep, and loss of motivation. He was placed on a wait list to see a psychiatrist.

23. Psychiatrist Dr Charles Chan assessed L in Parklea's Justice Health Clinic on 4 February 2016. L told Dr Chan that his family meant everything to him, and that he hadn't seen his children for many months. Dr Chan confirmed a diagnosis of major depression and noted L's ongoing difficulties with insomnia. He increased his dosage of quetiapine, and directed a review in six weeks to assess how L's mood and sleep were responding to the higher dose.

24. Dr Chan saw L again on 17 March 2016. L was still suffering insomnia and he expressed frustration with his medication and with the inefficiencies of the prison system. Dr Chan decided to cease L's quetiapine and instead prescribe the antidepressant mirtazapine, which has a sedating effect. He maintained the prescription of citalopram, and requested a further review of L to take place in 6-8 weeks.

25. In fact L never had another face to face psychiatric review. For reasons which are unclear a follow up psychiatric appointment was not immediately fixed. This was noticed on 13 May by mental health nurse clinician Robyn Osborne, who assessed L and directed a psychiatric review. On three occasions in the second half of May a psychiatric appointment for L had to be rescheduled. Then on 2 June L did not attend a psychiatric appointment booked for that day. No reasons have been uncovered for L's non-attendance, or for the need for the May appointments to be rescheduled.

26. However during April and May L did have meetings with psychologists Nicole Weaver and Andrew Redden, and with Nurse Osborne. At least two of these appointments were arranged by correctional officers who were concerned about L's state of mind. To these mental health clinicians L said he felt his medication was not effective and he voiced frustration that it was taking so long to obtain a psychiatric review. He reported feeling increasingly depressed about the future of his marriage, and his chances of receiving bail. Poor sleep continued to be a problem. On each occasion it is recorded that L denied thoughts of self harm or suicide.

27. On 27 April, following one of their daily phone calls L's wife A was sufficiently concerned about L that she contacted JH psychologist Andrew Redden. L was interviewed by correctional staff and encouraged to get help if he felt he needed it.

The self harm incident on 27 May and its aftermath

28. On 27 May L carried out an act of self harm by cutting himself to the chest with a razor blade. L cited rising distress at his family situation and his court proceedings as the cause for his actions.

29. L's act of self harm triggered a series of processes mandated by Corrective Services protocols. He was placed on what is known as a 'RIT' order. This is

made following an assessment by the Risk Intervention Team [RIT], a multidisciplinary team responsible for assessing an inmate's risk of suicide or self harm. The RIT is composed of staff from Corrective Services and Justice Health. Their task is to prepare a management plan with strategies to target the inmate's risk factors.

30. As part of L's RIT plan he was placed into an assessment cell located within the JH Clinic. Assessment cells have minimal fittings which provide almost no opportunities for hanging points, and have specially designed sheets known as safety blankets that are unable to be torn. Inmates are monitored by means of Closed Circuit television and frequent physical observations. The court heard that, not surprisingly, most inmates find it deeply unpleasant to be in the sterile and isolated environment of the assessment cell despite its physical safety features.

31. The RIT team assessed L again on 30 May and noted that he was denying any thoughts of suicide or self harm. They determined he could now have '*two-out cell placement'* and be further reviewed on 15 June. An inmate on two-out cell placement shares a normal cell with a selected cell mate, but must not be left alone at any time. The cell mate is to activate the cell alarm if there is any risk the inmate will carry out an act of self harm or suicide.

32. For L the problem with two-out cell placement was that it made him ineligible to carry out his prison work as a wing sweeper. For many inmates this work is valued because it allows additional time out of the cell, and earns money for privileges. On 6 June L requested that the RIT team review his status and give him normal cell classification once again. The request was denied and L had to wait until the scheduled review on 15 June.

The RIT review on 15 June

33. On 15 June L was reviewed by a member of the RIT team, Anthony Clarke. Mr Clarke is a Registered Nurse employed by Justice Health.

34. RN Clarke assessed that L could resume normal cell placement. As required by protocol, he discussed his assessment with another member of the RIT team who then co-signed the relevant Notification Form.

35. RN Clarke's notes of the review are very limited, recording only that L *'denies recent or current self harm of suicidal thoughts'*. At the inquest RN Clarke expressed regret that he had not more fully documented L's review. He described the JH Clinic environment as '*routinely chaotic'* due to its workload and thought it likely this had impeded him from completing proper notes that day. However he told the court about his usual practice when conducting such reviews. This was to carry out a risk assessment based on questioning and observation. RN Clarke was aware of L's desire to resume his work as a sweeper, which he (RN Clarke) regarded as an important safeguard for an inmate's wellbeing. He was certain that he would have documented any concerns had he assessed there to be any.

36. As a result of the review L was able to return to his shared cell in Area 2A. In the last two weeks of his life he made numerous phone calls to his wife. In many of these he expressed feelings of hurt and sadness and of not being able to carry on. His cell mate GJ stated that L's mood was '*like a roller coaster'*, worried and upset about his future one day and happier the next. He said that the night before he died, L was talking to him about his upcoming Supreme Court bail application.

37. Four days after L's death his wife A received a letter in the mail from him dated 7 July. He asked her not to read it until the day fixed for his bail review. In the letter he expressed hurt that A had someone else in her life. He wrote that if he didn't get bail he could not *'do another nine months of this'* and that *'not being with you and the kids is slowly putting me deeper and deeper into depression as without you and the kids in my life it is not worth living'.*

The cause and manner of L's death

38. The autopsy report of pathologist Dr Istvan Szentmariay recorded the direct cause of L's death as '*hanging'*. L's family has expressed a preference that the cause of his death be recorded as '*asphyxiation by ligature'*, and this is what I have done.

39. As for the manner of L's death, the evidence above is more than sufficient to find that L died as a result of an intentional act to end his own life. He had a significant depressive disorder and he was deeply pessimistic about the future of his marriage and the prospect of facing a lengthy time in prison. L took what steps he could while in jail to address his mental health. He actively sought mental health services and did what he could to maintain his work as a sweeper. Sadly his situation overwhelmed him. It was in these circumstances of deep depression and despair that L made the decision to end his life.

The issues at inquest

40. The manner of a person's death also encompasses the circumstances in which the death occurred. In L's case the circumstances explored at the inquest were L's state of mental health, the contribution it made to his death, and the adequacy of the mental health services he received as an inmate at Parklea.

41. The inquest also examined certain other issues with the aim of considering what might be done to reduce the incidence of suicide hanging deaths in custody. L's death in a state of despair is sadly not uncommon in NSW prisons. The Coroners Court is obliged to examine whether reasonable steps can be taken to reduce the incidence of these terrible events, which impact the lives of so many people. These include not only the families of those who have died, but also those who live and work within the prison system.

42. In examining what preventive measures might feasibly be taken, the inquest heard evidence about the availability of hanging points in the cells of The

inquest also examined certain other issues with the aim of considering what might be done to reduce the incidence of suicide hanging deaths in custody. Parklea and what steps have been taken, and may still be taken, to reduce their presence.

The report of Dr Olav Nielssen

43. The Court was assisted with expert evidence from Dr Olav Nielssen about L's state of mental health and the adequacy of his mental health care.

44. Dr Nielssen is well qualified to provide this assistance. He is a consultant psychiatrist with many years' experience providing specialist services for prison inmates. During the years 1993 to 2008 he was a Visiting Psychiatrist for Justice Health, in which role he provided psychiatric services to Parklea inmates for a period of time. Among his current appointments he is a Visiting Psychiatrist at St Vincent's Hospital Sydney and a Clinical Professor of Psychiatry at Macquarie University Faculty of Medicine and Health Sciences.

45. From his review of the evidence, Dr Nielssen confirmed that around the time of his death L was most likely suffering a major depressive illness, with symptoms of depressed feelings, negative ruminations, suicidal thoughts and poor sleep. L had probably developed this condition in response to being charged with criminal offences in 2014, and it appeared to have become more severe in the months before his death.

46. Dr Nielssen was asked his opinion as to the appropriateness of L's medication while in custody. In his view L was prescribed the appropriate medication for his conditions, namely citalopram for depression and mirtazapine to help address ongoing issues with sleep.

47. Regarding the medical care L received for his mental health issues, in Dr Nielssen's opinion this was *'of an adequate standard and was appropriate to his reported symptoms'.* He noted that L had a number of appointments with a mental health nurse and with prison psychologists, and two with a specialist psychiatrist. Furthermore the prison health services responded promptly to each sign of suicide risk by arranging mental health treatment and review, and restricting L's opportunities for self harm after the incident on 27 May.

48. Indeed, Dr Nielssen considered the level of mental health treatment provided to L was *'far better than that received by most prisoners in similar circumstances'.* This statement however must be seen within a context in which, as Dr Nielssen described it:

- there is a disproportionate amount of psychiatric and psychological disorder in the prison population
- mental health care cannot be delivered efficiently in prisons, due to the limited time prisoners are allowed outside their cells
- he has regularly encountered prisoners who have not yet been assessed despite having months of untreated symptoms.

49. Dr Nielssen was also asked to comment on the fact that L did not receive a psychiatric review after 17 March 2016. In his opinion this ought to have occurred, notwithstanding the Clinic's heavy workload. It would have provided an opportunity to consider whether a different antidepressant might have provided better results for L over time.

50. However Dr Nielssen was not willing to assert that had L received a psychiatric review after 17 March, this may have altered the tragic outcome. In his opinion the triggers for L's depression were largely external, being his family and his court situation. Medication alone was unlikely to be able to alleviate L's mental ill health – recovery would require him to develop a different way of approaching his problems.

51. Dr Nielssen was also asked whether the decision on 15 June to restore L to normal cell placement was appropriate. He acknowledged that when viewed in hindsight, it was not. Nevertheless from a prospective point of view the decision was '*reasonable and understandable'*. The self harm of 27 May was of a superficial nature, and to his clinicians L consistently denied suicidal plans. He was also keen to resume his work as a wing sweeper, which Dr Nielssen agreed can be a therapeutic activity. For these reasons Dr Nielssen was not willing to conclude that the decision was an unreasonable one.

Conclusions regarding L's mental health care

52. Considering firstly the appropriateness of L's medication, this was a concern held by L as well as by his family. Nevertheless in Dr Nielssen's view L was receiving the proper medication for his condition. There is no basis to reject this opinion. When considering L's dissatisfaction with his medication moreover, Dr Nielssen's comments need to be borne in mind: that the causes of L's depression lay very much in his situation, and that it was unlikely that medication was capable of removing the stresses imposed by it.

53. Turning to the adequacy of L's mental health care, it remains unclear why he did not receive further psychiatric review after 17 March. It is also unclear why L did not receive any psychological services in the seven weeks following his self harm incident and his death on 14 July.

54. Nevertheless Dr Nielssen was unwilling to conclude that a greater frequency of psychiatric and psychological services would have led to a better outcome for L, for the reason referred to in paragraph 50 above. Given this evidence I accept the submission of Counsel Assisting, that it is not apparent that any changes to L's care and treatment would have necessarily prevented his death.

55. As for whether the care and treatment L received was of an adequate standard, this was Dr Nielssen's view albeit one which ought to be seen within the context of his opinion that prison mental health services overall are overstretched and inefficient. I accept Dr Nielssen's opinion regarding L's care and treatment in Parklea.

The adequacy of custodial mental health services generally

56. The above conclusion ought not be taken as acceptance of the proposition that overall resourcing for prison mental health services is adequate. This issue was outside the scope of the inquest and it is not appropriate to make specific findings about it.

57. Nevertheless in keeping with the preventive role of the Coroners Court, it is appropriate to highlight in a general sense, evidence received at the inquest about the under resourced nature of mental health services within NSW prisons and the risk this presents.

58. In addition to that of Dr Nielssen the court heard other evidence about the overstretched nature of prison mental health services.

59. Mr Trevor Perry is Service Director of Custodial Mental Health, Justice Health. At the inquest he commented that the level of resources specifically for custodial mental health services had not matched increases in the NSW prison population. This was a particular challenge for Parklea due to its large proportion of remand and reception prisoners, who require a high level of frontline screening and diagnostic services.

60. Also tendered in evidence at the inquest was the December 2018 report of the NSW Legislative Council's Committee of Inquiry into the operations of Parklea. Among others the Committee identified as an issue of concern the level of resourcing for mental health services at the prison. Chapter 7 of the report documented evidence of the overall increase in inmates with serious mental health issues, and the insufficiency of clinician numbers to provide timely diagnosis and treatment for these inmates. At paragraph 7.32 the Committee concluded:

'It is very clear to us, based on evidence presented during this inquiry, that while the inmate population has increased markedly, and the correctional system has received substantial resources to address this demand, the Justice Health system has not, and thus struggles to meet the vast tide of inmate's health needs'.

61. The Committee called for '*substantial investment'* in Justice Health services generally and mental health services and infrastructure specifically, commenting at paragraph 7.41:

' …We can only highlight that adequate investment here will protect individual and public health, will enable the provision of care in the setting to which patients are entitled, and will greatly relieve pressure within the correctional system'.

62. This led to the Committee's Recommendation 14:

'That the NSW Government, over and above its recent investment in mental health services and infrastructure from 2018-19 …provide sufficient additional resources to the Justice Health and Forensic Mental Health Network to enable it to meet the

health needs of the NSW prisoner population, and their mental health needs in particular'.

63. The Parliamentary Committee's recommendation seems particularly timely, given that Parklea will soon experience a large increase in inmates with the opening of its new facility. The evidence referred to in paragraphs 59-61 gives rise to concern about the capacity of Parklea's mental health services to meet the inevitable increase in demand for care.

What can be done to reduce the incidence of hanging deaths in custody?

64. Bearing in mind the above, when considering what recommendations if any might fairly arise from the facts in this inquest, the court confined itself to examining whether any measures might be undertaken to reduce the opportunities for inmates to end their lives in the way L did.

65. Written submissions made on behalf of L's family documented nine suicides by hanging at Parklea between 2010 and May 2017. Five of these took place in 2016 and 2017, in each case by means of a rope fashioned from bed linen and anchored to an area within the cell. In all cases the inmate had been cleared for normal cell placement.

66. These figures highlight that the risk of hanging is present even in the case of inmates who are not identified as '*at risk'*, bearing out Dr Nielssen's observation that suicide in jails is difficult to predict and the importance of minimising opportunities for it.

Suicide mitigation strategies at Parklea: hanging points

67. There have been attempts to implement suicide mitigation strategies at Parklea. Their primary focus has been to reduce the risk factors posed by the fittings within cells.

68. Hanging points are a well recognised problem in the custodial environment, and have long been a matter of coronial concern. In older correctional centres such as Parklea the risks are heightened because the design of their fittings tends to present greater opportunities for self harm. The evidence at inquest included photographs of the furniture and fittings within L's cell. Even to the layperson it is apparent they offer numerous points from which a ligature can be hung, including open style railings at the side and ends of each bunk, and open slat ladders.

69. In 2012 the GEO Group undertook work at Parklea which replaced taps, spouts and shower heads with designs offering fewer obvious hanging points. This refurbishment was in response to recommendations made by CSNSW following the hanging death of an inmate TH. At that time GEO Group recorded it was undertaking a more extensive review of the risks posed by other fittings, including curtain rails, shelving and bunk beds.

The 2017 Action Plan

70. A review by GEO Group in 2017 resulted in the document *'Action Plan – Vulnerable Inmate Management and Suicide Prevention Strategies'.* The stated objectives of the Action Plan were to:

- review and identify the most appropriate and cost effective way to significantly reduce and eliminate obvious hanging points in Parklea's normal placement cells
- implement a funded project to remove obvious hanging points identified within Parklea's normal placement cells.

71. The Action Plan strategies included removal of fixtures such as shower curtain railings, metal louvres fitted to windows above the cell doors, and metal bars anchoring shelving units to walls. In the 2017 inquest into the death by hanging of another Parklea inmate P, her Honour Magistrate Grahame recommended that urgent funding be provided to implement these strategies.

72. In the current inquest the court heard that the work recommended in the 2017 Action Plan has largely been completed. This is a positive development, and evidences commitment by those responsible for Parklea inmates to reduce the known risks of hanging deaths. It is also commendable that the 2017 Action Plan recognised that suicide risk is present in normal placement cells, and not just in special cells for *'at risk'* inmates.

73. However, it will also be noted that the risk posed by bunk bed design did not form any part of the Action Plan strategies.

The report of Perumal Pedavoli Architects

74. In 2018 CSNSW engaged Perumal Pedavoli Architects [PPA] to identify ligature risk issues in normal placement cells. PPA was asked to review all the cells in Parklea's Areas 1, 2 and 3. The result was a preliminary report titled '*Review of Ligature Points in Existing Cells'*. The PPA team reviewed a wide range of fittings including bunk beds, cell windows, cell desks, door handles, wash basins, and light fittings.

75. Of relevance to this inquest, the bunk beds reviewed by PPA included the same design as that which L had used to end his life. The PPA report confirmed that these beds and others of similar design in use '*present numerous ligature risks due to gaps, openings'.*

76. However the PPA 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 which would address all the identified major risk items. They commented at Part 7.2 of the report:

'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 standards'.

77. The PPA report concluded that further work was needed to address the identified risks at a more specific level.

78. Despite this the inquest heard there are no current plans to commission further consultants to address at a more specific level the issues identified in the PPA report. The reasons were articulated by Ms Julie Ellis, who is a Director of CS's Governance and Continuance Improvement Division. With reference to the PPA report she commented in the second of her two statements:

'It will be apparent from that high level review that a permanent solution that would reduce significantly (or entirely eliminate) all hanging risk would require complete refits at a significant cost. There are clearly major infrastructure and cost constraints that would require high level government budgetary commitments before that could occur'.

79. The evidence therefore is that aside from the work being undertaken for the new facility discussed below, no further work is planned to replace or refurbish the fittings and furniture in Parklea cells, or to otherwise address the suicide risks they present.

The new facility at Parklea: proposed fit out

80. Before moving on to the question of whether recommendations should be made, it is relevant to make some observations about the proposed cell design for the new facility at Parklea. The new facility is expected to become operational later this year and will have capacity to house 400-500 more inmates, increasing total capacity to about 1300 inmates.

81. At the request of the Coroner the inquest was provided with information about the designs which are proposed for the fit out of the new cells, with the caveat that the designs may be subject to change. Acknowledging this I will not comment on the details of the proposed designs, except to say that when the designs are examined it seems clear that one of the objectives has been to reduce the availability of hanging points in the cells. In the new two inmate cells the proposed beds are not double bunk style, eliminating the need for ladders and safety railings. In the new single inmate cells there is a redesigned double bunk bed which we were advised was to address likely increases in inmate population. The proposed double bunk bed design does not incorporate any open areas in its ladder or upper bunk railing. The designs for both types of cell show shelf units set into the wall without anchoring bars.

82. It is evident even from the perspective of a layperson that the designs if adopted would reduce many of the risks identified by the PPA authors in the older style cells of Areas 1, 2 and 3.

Question of recommendations

83. After a careful review of the evidence, Counsel Assisting the inquest proposed that three recommendations be made. Submissions in response to the proposals were received from L's family, and from CSNSW and Justice Health. GEO Group and the Nurses and Midwives' Association declined to make any submissions. The new operator of Parklea, MTC/Braodspectrum, was also invited to respond to the proposals but declined to do so.

84. The first proposal is that CSNSW and/or the new Parklea operator MTC/Broadspectrum consider reviewing the method by which inmates are called to a Clinic appointment by announcement over the PA system, and that other options be explored as additions or alternatives.

85. I have noted that in L's final weeks, three of his psychiatric appointments had to be rescheduled and he failed to attend his final one. The inquest was told by GEO Correctional Officer WA, and by Manager Tony Mannweiler that they were aware of instances where inmates had missed appointments due to not hearing the PA notification because of noise levels in the recreational yard. Further, in his statement Mr Trevor Perry said that some protected custody inmates like L may be reluctant to attend the Clinic in answer to a call that identifies them over the PA system.

86. Submissions on behalf of the Commissioner for CSNSW were that announcements via the PA system were not the primary means by which inmates were notified of Clinic appointments. Inmates were informed of the time of their appointment at the morning muster. Nevertheless the Commissioner undertook to attempt to improve the clarity of the PA announcements.

87. Through her representatives, L's wife A strongly supported the proposal that there be a review of the above method of calling inmates to a Clinic appointment. In her evidence at the inquest A mentioned L telling her that he had not been able to hear his name being called over the PA system.

88. I adopt this proposal. Given the importance of such appointments and the overstretched nature of prison mental health resources, every effort should be made to minimise impediments to attendance.

89. The second proposal is that CS and/or MTC Broadspectrum consider examining options for using tear resistant sheets in normal placement cells. Counsel Assisting noted that L appeared to have had little difficulty tearing and twining his standard bed linen into a ligature. The submissions on behalf of the family documented four other instances in 2016 and 2017, in which Parklea inmates had hanged themselves using their bed linen.

90. The Court heard that the only alternative currently in use, the safety blanket used in assessment cells, is notoriously uncomfortable because it has metallic thread through its fabric. This is what makes it tear resistant.

91. In their submissions L's family supported this proposal. Submissions made on behalf of CSNSW were that the safety blanket was not a viable option for general use because its discomfort would impose hardship on inmates.

92. It is not proposed that the safety blanket replace existing bedding for normal cell placements. The proposal is that options be explored for an alternative to the existing sheets which would provide greater resistance to tearing. Although Ms Ellis told the inquest she was aware there had been such research over the years she was unaware of the details. This is not a criticism of her evidence, as the specific issue of prison sheets emerged as an issue during the inquest and was not specifically identified before it commenced.

93. In my view there should be work done to explore and cost an alternative to the standard issue bed linen which is more resistant to tearing. In my opinion this project is justified by the prevalence within the custodial environment of hanging with the use of bed sheets. If there is a viable alternative this would represent a useful suicide mitigation strategy.

94. The third proposal is that consideration be given to replacing the existing bunk beds in Areas 1, 2 and 3 with a design similar to that proposed for the new facility. Counsel Assisting in her submissions acknowledged the likely unfeasibility of replacing all fittings and furniture in Areas 1, 2 and 3. In her submission however replacing the bunk beds should be considered as going some way to addressing the particular risks they presented.

95. At the inquest further information about the design of existing beds in Areas 1, 2 and 3 was sought and obtained from CSNSW, and tendered as Exhibit 2. This material shows that Areas 1, 2 and 3 contain almost 300 double bunk units. By reference to photographs included with the material it can be seen that 92 of these bunk units are identical to that which L used to end his life. They feature open space railings at the side and at each end of the bunks, and open slat metal ladders. The other approximately 200 bunk beds in use in Areas 1, 2 and 3 are substantially similar, with many visible hanging points. This thumbnail analysis by no means provides a comprehensive assessment of the risk presented by the current bed fittings, but it is sufficient to identify that the number of Parklea inmates who are using bed furniture that has been described as offering numerous ligature points is very significant.

96. Submissions made on behalf of CSNSW did not support the proposal that consideration be given to replacing the bunk beds in Areas 1, 2 and 3. The submissions highlighted the very substantial practical and financial implications that would be involved. These included:

- the absence of evidence at this stage that bed units designed for a different cell would be able to fit into the existing cells of Areas 1, 2 and 3

- the questionable effectiveness of retrofitting existing cells with new and safer furnishings, noting the comments made by the PPA authors at paragraph 76

above, that such an exercise may not result in a safer cell unless a '*whole of cell'* approach was taken

- the costs of retrofitting the existing cells, which '*may prove no less prohibitive than rebuilding the facility*'. As observed by Ms Ellis in her evidence, such costs would require a high level of government budgetary commitment. Further, CSNSW would need to consider similar measures across its network of NSW correctional facilities

- the practical impediment of finding alternative accommodation for hundreds of Parklea inmates while the refit took place.

97. With reluctance I have come to the view that however necessary and desirable it is that there be mitigation of the risk presented by the existing bunk beds in Areas 1, 2 and 3, it would not be feasible to make the recommendation sought. The inquest did not hear any evidence as to whether or not the new safer beds are able to be installed in the older cells of Areas 1, 2 and 3. Furthermore the other fittings within the cells would continue to present ligature risks. I also accept there is a probability that the costs involved in eliminating or substantially reducing existing hanging points as recommended by the PPA authors could exceed the cost of a complete rebuild of those areas. These practical and financial impediments appear insuperable.

98. For the reasons given above I have determined it is not feasible to make the specific recommendation proposed. However the fact remains that a large proportion of Parklea inmates continues to be housed in environments which present significant self harm risks. The issue is well understood and has been so for a number of years. There is a compelling need for those responsible to mitigate this risk by providing accommodation which conforms with current safety standards.

99. In closing, and on behalf of the coronial team, I offer my sincere and respectful sympathy to L's family. I hope this inquest has answered some of their questions about his very sad death.

100. I acknowledge the excellent assistance I have received from those assisting the inquest Ms Palianiappan of Counsel and Ms Skinner of NSW Crown Solicitors Office, and from all legal representatives appearing in the inquest. I also thank Detective Sergeant Joseph Coorey for his investigation of the matter and preparation of the coronial brief of evidence.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is L.

Date of death:
L died on 14 July 2016.

Place of death:
L died in his cell at Parklea Correctional Centre, Quakers Hill NSW.

Cause of death:
L died as a result of asphyxiation by ligature.

Manner of death:
L's death was intentional and self-inflicted, in circumstances where he was an inmate in Parklea Correctional Centre.

Recommendations pursuant to section 82 of the Act

1. To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that consideration be given to reviewing the method by which inmates are called to a Clinic appointment by announcement over the PA system, and that other options be explored as additions or alternatives.

2. To the Commissioner of Corrective Services NSW and to MTC/Broadspectrum: that options for obtaining tear resistant sheets for inmates in normal cell placement be explored and costed as an alternative to the normal bedding issued to inmates.

I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date 30 April 2019