STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of P
Hearing dates:	23 October 2017
Date of findings:	10 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame
Catchwords:	CORONIAL LAW – Death in Custody, hanging point in cells
File numbers:	2014/59894
Representation:	Mr A Creagh, Coronial Advocate assisting
	Ms S Li, solicitor for Justice Health
	Mr A Jobe, solicitor, Office of General Counsel for the Commissioner of Corrective Services

Findings

Identity

The person who died was P.

Date of death

P died on 25 February 2014.

Place of death

P died at Parklea Correctional Centre, Parklea, NSW.

Cause of death

P died from hanging.

Manner of death

P's death was intentionally self-inflicted.

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Recommendations

To Commissioner of Corrective Services

I recommend that urgent funding be provided to facilitate the removal of hanging points in prisoner cells in Parklea Correctional Centre in accordance with the Action Plan prepared by the GEO Group Australia Pty Ltd, dated 1 September 2017.

Non-Publication orders

Pursuant to section 74, I order that there be no publication of the following material,

1. The names, addresses, and phone numbers of Mr P's family members or visitors (other than legal representatives or visitors acting in a professional capacity) found within the brief of evidence.
2. Inmate Accommodation Area Journal (tab 9);
3. The CCTV footage (tab 12, and tab 24 of Police Brief);
4. Hand-held footage (tab 25 of police brief)
5. Inmate Profile Documents - Ansford, Kheir & Ballard (including the names of those inmates visitors) (tab 27);
6. CSNSW Photographs (tab 28) ;
7. Parklea Daily Roster dated 25 February 2014 (tab 29);
8. Gaol List of Inmates and Wings 25/02/14 (tab 30);
9. Operations Procedure Manual section 13.2 – Deaths in Custody (tab 33);
10. Operations Procedure Manual section 13.8 – Crime Scene Management (tab 34);
11. Parklea Operating Manual Policy No. PCC/OP003 (tab 35);
12. Parklea Emergency Order Policy No. PCC/EO07 (tab 36);
13. Parklea Operating Manual Policy No. PCC/OP010 (tab 37);

Pursuant to section 75, I order that there be no publication of the name or identifying information of the deceased or his partner. Initials may be used as pseudonyms.

Pursuant to section 75(5) I permit publication of the information contained in these findings in accordance with the above restrictions.

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Introduction

1. P was 42 years of age at the time of his death. He was serving a term of imprisonment at Parklea Correctional Centre. That gaol is privately operated by the GEO group Australia Pty Ltd (GEO), through a contractual agreement with the Commissioner of Corrective Services. Parklea Gaol is in metropolitan Sydney.

2. On 14 February 2014, P appeared at Newcastle Local Court in relation to a number of property offences. He was granted bail. One of the conditions included that an acceptable person must deposit and agree to forfeit $2000 in cash. This condition was not met and P remained in custody. He was kept briefly at Penrith Court cells. On 16 February 2014 P was moved to Amber Laurel Correctional Centre.

3. On 18 February 2014, P was assessed by a registered nurse at Amber Laurel. At that time P indicated that he had no history of mental health problems and no history of self-harm or suicide attempts. It was recorded that he had a recent history of intermittent chest pain and that he should be observed for faintness, pain to the left side of his chest, or skin that may appear clammy, cold or pale. He was taken to Nepean Hospital and assessed. No physical abnormality was found.

4. On 20 February 2014, P was transferred to Parklea Correctional Centre. He was seen there by a registered nurse and again indicated that he had no history of mental health problems and no history of self-harm or suicide attempts. He was considered suitable for "normal cell placement". P was then housed in the ground floor area 3C, which was an area primarily reserved for fresh inmates.

5. On 25 February 2014, P was released into the common area of 3C around 12:10 PM with other mostly new inmates. He made a telephone call from the offender telephone system in the common area to his partner L at 12:40 PM. During the phone call L indicated that she did not want P to live with her when he was released, and that she wanted to end their relationship. P stated that he would "neck himself", and that he "couldn't deal with it".[1]

6. The phone call finished around 12:44 PM. P returned to his cell about 12:51 PM after a brief period in the common area. Correctional officers conducted a "lock in" of the cells between 1:10 and 1:15 PM. At about 2:06 PM, CCTV showed an inmate stand outside P's cell.[2] This inmate was R who was performing the role of "sweeper" in the area. This role included handing out laundry bags on Tuesdays and Fridays. He recalled banging on the cell door, but receiving no response. He heard a small movement which he thought may have been someone getting off the bed, but the door was not opened. The window on the cell door was almost entirely covered. Through a small gap he could see that it was completely dark in the cell. R waited at the door for about 30 seconds before continuing on his rounds.

7. CCTV surveillance shows that P's cell remained closed until correctional officers were conducting a routine muster of the pod at about 3:15 PM. At that time officers opened the cell and observed that P appeared to have hanged himself, using a torn bed sheet secured to a part of the window. Officers cut the material wrapped around P's neck and began first aid. At

[1] See transcript of call, Exhibit 1, Tab 10
[2] Exhibit 1, Tab 23

3:22 PM nursing staff attended the scene and continued the resuscitation attempts. Paramedics arrived at 3:47 PM to assist, however P could not be revived and he was pronounced dead at 4:12 PM.

8. A post-mortem examination was conducted on 26 February 2014. The forensic pathologist conducting the examination confirmed that P's death was caused by hanging. He was later formally identified by fingerprint analysis.[3]

9. 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.[4] There is sufficient evidence to establish that P consciously intended to die on 25 February 2014 and that he undertook the necessary steps to kill himself. His proximate conversation with Ms L signalled his intention and the deliberate conduct he undertook to make a noose is relied upon. I note that toxicological testing revealed that he was not affected by drugs or alcohol at the time of his death.

The role of the coroner

10. 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.[5] 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.[6]

11. In this case there is no dispute in relation to the identity of P, or to the date and place of his death. For this reason the inquest focused on the manner and cause of his death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring.

12. Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner[7]. 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.

13. 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 P.

Scope of the inquest

14. A number of issues relevant to P's death were identified prior to the inquest commencing. These issues included

[3] Exhibit 1, Tab 37
[4] 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)
[5] Section 81 *Coroners Act* 2009 (NSW)
[6] Section 82 *Coroners Act* 2009 (NSW)
[7] See sections 23 and 27 Coroner's Act 2009 (NSW)

- Should P have been considered a suicide risk on reception?
- Should officers have been aware of his recent threat to "neck himself"?
- What steps are still necessary to remove or reduce the risk of inmates hanging themselves?

15. The inquest took place on 23 October 2017. A large number of statements were tendered, along with recordings, gaol and medical records. Detective Senior Constable Melissa Martens gave short oral evidence.

Background

16. P was born on 8 March 1971. He grew up in Toronto on Lake Macquarie with his parents and siblings. It is reported that he had a fairly happy childhood and had extended family living in the local area.

17. P's criminal record commenced in his teenage years and reflects the kind of offences associated with drug use. It is reported that he developed a drug problem from a young age using cannabis and later heroin and amphetamines. There was some family discord in relation to money and over the years P lost touch with most of his family.

18. P had two sons from an earlier relationship and at the time of his death was involved with L. They lived together, along with her children from an earlier relationship. L reports that P had a serious gambling problem and that this caused major tension in their relationship.

19. Prior to arrest in February 2014, L had been increasingly concerned about P's mental health. He was behaving strangely and had threatened self-harm. Nevertheless, Lwas apparently used to P making these types of threats and did not think that he would actually harm himself.

Should P have been considered a suicide risk on reception?

20. Despite his denial of suicide ideation or self-harm risk on reception into custody in February 2014, when one carefully reviews the complete Justice Health file for P there is some evidence of a prior suicide attempt back in 2001. A number of entries relating to P from March 2001also indicate that he had a history of depression for which he had been medicated. It was recorded that he had taken an overdose of Doxepin six months previously "when it all got too much for him".

21. A Mental Health Assessment questionnaire completed on 15 March 2001 records a history of depression and a prior suicide attempt. It appears that this attempt took place in the community.

22. There does not appear to be any further recognition of this event in the file and later documents make no reference to it. On the contrary, it appears that all later assessments do not record a prior suicide attempt.[8] Each of these documents appears to have been completed during a face-to-face interview with P and relied on information he provided.

[8] See for example documents filled out on 7 July 2004

23. P also makes no reference to feeling suicidal when questioned on his most recent reception. There are five forms filled out between his transfer from Amber Laurel and his reception at Parklea on 20 February 2014. Each indicates that he has no history of self-harm or suicde.[9] It may be that P did not feel the attempt back in 2001 was relevant to disclose. It may only be that it was not until he spoke with his partner on 25 February 2014 and found out that their relationship was apparently over, that his suicidal feelings emerged.

24. From the information before the court, there is no recorded reference to self-harm for 13 years. It appears that P had no documented attempt of self-harm whilst in custody and one would not have expected to have seen an alert on his file in this regard. Equally, on the information he provided to Justice Health and the GEO group, there was nothing at February 2014 which would have suggested that his file should have had a new "Self-harm – risk" alert placed on it.

25. As far as prison authorities were aware there was nothing to suggest that P needed to be placed with another inmate or in an observation cell. In fact P was placed with another inmate on 21 February 2014, but that inmate was released on bail the same day. While it can be a useful protective mechanism, there was nothing on file to suggest that P needed to be placed "two out".

Should officers have been aware of his recent threat to "neck himself"?

26. While there is no evidence that P disclosed to anyone but L that he would "neck himself", protocols in place within Parklea Correctional Centre give prison officers the power to monitor telephone calls. [10] The court has been provided with a recording of P's call to L. He is heard to say "I'll neck myself…I can't deal with it hey…I can't deal with it"[11]. However there is nothing to suggest that anyone in the prison environment heard the call until well after P's death. It is not suggested or reasonable that the prison should institute real time surveillance of all calls in case a prisoner should express self-harm. It is also evident that L did not alert prison authorities of the content of the call prior to P's death. It appears that in the context of their relationship, she had no reason to believe it was a serious or imminent threat.

27. The court had the opportunity to review the call. While the call took place in a common area, it was made away from other inmates and staff. P only raises his voice slightly when he says he will "neck himself" and quickly returns to a fairly level tone before he ends the call. A staff member would have had to be listening extremely carefully to realize that P was distressed. Prison staff would have been attending to a number of other tasks when P made the call and Paul, like most prisoners would have wanted privacy.

[9] See the following documents "Police Cell complex – Reception Triage Process" completed 18 February 2014 at Amber Laurel Correctional Centre; New Health Problem Notification, completed 18 February 2014; New Health Problem Notification Form, completed 20 February 2014; Reception screening and induction checklist, completed 20 February 2014; Corrective Services NSW intake screening questionnaire.

[10] The Court was provided with Corrective Services Policies which indicate that calls may be monitored, but does not indicate when or in what manner this will occur.

28. In my view, given that it appears P killed himself within hours of having threatened self-harm in a private telephone conversation to his partner, officers cannot be criticised for having no knowledge of the imminent risk.

What steps are necessary to remove or reduce the risk of inmates hanging themselves?

29. One of the tragedies of P'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,[12] Corrective Services NSW conducted a state-wide survey and audit of the Corrective Services estate for obvious hanging points and "high risk" furniture installations.[13] This has 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.

30. GEO was informed of this inquest, but was not represented. However, the court was supplied with a document entitled "Action Plan – Vulnerable Inmate Management & Suicide Prevention Strategies" (dated 1 September 2017)[14] prepared by GEO operational staff to address suicide mitigation strategies. Although GEO stated that the plan had not been created for or in contemplation of this inquest, it deals with a relevant issue. GEO is clearly aware of the risk of suicide in prisoners who have not previously been identified as "at risk". It appears that GEO is confident that it has some useful strategies in place for inmates known to be exhibiting self-harm behaviours, but is aware that it needs to develop strategies to address possible self-harm in inmates who may not have been displaying "at risk" behaviours. Thus it is recognised that inmates, such as P, in a "normal" cell placement, who have not identified themselves as being at risk and are not identified by Justice Health or correctional officers as being at risk, may also develop a suicidal plan. Their actions may be sudden, impulsive and unexpected.

31. Many of the changes that can still be made are simple. Removal of shower rods and window louvres can make a difference. Changes to lighting and shelving can also remove obvious hanging points.

32. One of the purposes of the Action Plan is "to review the physical nature of the cells to identify the physical factors that may contribute to the suicide ideation of inmates and further mitigation and remove as many of these risks from all cells within the centre".[15] Given that GEO is the operator, not the owner of the physical assets, approval of the mitigation strategies requires the financial backing of Corrective Services NSW.

33. An addendum to the Action Plan was supplied to the court and it is clear that some strategies identified have yet to be costed and fully implemented. Guaranteed funding for these works appears to be a matter of urgency. This issue has been well understood for many years and it is shameful that these changes have not already been made.

[12] Inquests into the deaths of Desmond Walsley and Manoa Tupou.
[13] See correspondence from Todd Jeffries, Senior Assistant Superintendent, Custodial Corrections Branch, Corrective Services NSW, dated 1 September 2016
[14] Exhibit "Action Plan – Vulnerable Inmate Management & Suicide Prevention Strategies" (dated 1 September 2017) Exhibit 1, Tab 36
[15] Exhibit 1, Tab 36

The need for recommendations

34. It appears that GEO has now identified a number of further strategies in relation to suicide mitigation for inmates in "normal cells" as well as those in special cells for "at risk" inmates. This is especially important when one considers the experience of P. He was not known to have been "at risk" and his death may have been hastily planned and impulsive. His method of death was made possible by the physical environment he was in. Obvious hanging points must be eliminated wherever possible.

35. The physical assets are not owned by GEO and it requires funding to be allocated by Correctives Services to complete the work identified. For this reason the recommendation I make under section 82 of the Act is directed to the NSW Commissioner for Corrective Services, not GEO.

Conclusion

36. P's death was unforseen by those entrusted with his care. I accept that his decision to take his own life was sudden and unexpected. Sitting alone in his cell, ruminating on the breakdown of his relationship appears to have caused him profound despair. Had he not been able to attach his torn bed sheet to the window so easily, he may have survived until he was released back into the common area later that day. P is not the only prisoner to have died in these circumstances. Urgent action must be taken to improve conditions at Parklea and elsewhere.

37. Finally I offer my sincere condolences to P'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.

38. I close this inquest.

Findings

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

Identity
The person who died was P.

Date of death
P dies on 25 February 2014.

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

Cause of death
P died from hanging.

Manner of death

P's death was intentionally self-inflicted.

Recommendations

I make the following recommendation pursuant to section 82 of the Act,

To Commissioner of Corrective Services

I recommend that urgent funding be provided to facilitate the removal of hanging points in prisoner cells in Parklea Correctional Centre in accordance with the by Action Plan prepared by the GEO Group Australia Pty Ltd, dated 1 September 2017.

Magistrate Harriet Grahame
Deputy State Coroner
10 November 2017
NSW State Coroner's Court, Glebe