STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of SW
Hearing dates:	15 July 2015
Date of findings:	15 July 2015
Place of findings:	Glebe Coroners Court
Findings of:	State Coroner Magistrate M A Barnes
Catchwords:	CORONIAL LAW – Cause and manner of death; death in custody; intentionally self-inflicted; assessment of self-harm risk
File number:	2014/161167
Representation:	Sgt E Mulligan: Advocate assisting the State Coroner Mr G Singh: Justice Health Ms S Binnie: Department of Corrective Services

Findings	**The identity of the deceased** The deceased person was SW. **Date of death** SW died on either 27 or 28 May 2014. **Place of death** He died Cessnock in New South Wales. **Cause of death** The cause of SW's death was hanging. **Manner of death** SW's death was intentionally self-inflicted while he was serving a sentence of imprisonment in the Cessnock Correctional Centre. I am satisfied that no third party played any role in his death and no actions or inactions of correctional staff contributed to the death which was unforeseen and unexpected.

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The Coroner Act 2009 in s81 (1) 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 SW. As SW was in custody at the time of his death an inquest is mandatory.

Introduction

The evidence

Social history

SW was born on the 22 December 1972 at Loganlea in Queensland. At the time of his death SW was 42 years of age. The limited background information known of SW was supplied by his Uncle RW.

SW was born in Australia but moved to England as a small child with his sister. They were raised by RW. Around the age of 12 SW was involved in a serious motor vehicle collision resulting in a head injury.

Later SW committed a number of robbery offences whilst still in England and was subsequently sentenced to a time of imprisonment. On release SW returned to Australia.[1]

SW had no real family ties. He never married and had no children. It appeared SW was homeless prior to his arrest. He had no family visitors during his most recent period of imprisonment and made no phone calls.

Criminal History

SW had previously been convicted in Queensland of two offences, Break and Enter Dwelling with Intent and Threaten Violence whilst Armed. SW served a custodial sentence in Queensland for these offences.[2]

On 9 July 2013 SW was received into Corrective Services NSW (CSNSW) custody at Surry Hills court cell complex as a result of being charged with the offences of Assault with Act of Indecency and Detain a Person with Intent to Obtain Advantage.

On 10 July the SW was transferred to the MRRC Silverwater.

On the 24 July 2013 SW was convicted of the two offences. SW was sentenced to 4 years imprisonment, with a non parole period of 3 years. His earliest release date was to be the 7 July 2016.

Mental Health Assessment on reception at MRRC Silverwater

On the 10 July 2013, on intake at the MRRC, SW disclosed a history of epilepsy, post traumatic stress disorder, dependency on alcohol (2 bottles of whiskey per day), withdrawal related seizures and epilepsy. He denied any thoughts of self-harm.

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[1] Statement of Detective Sergeant Bradley YOUNG, paras 39 & 40

[2] Ibid para 5

The following day SW had a drug and alcohol follow up and was continued on Thiamine and a decreasing Diazepam regime for withdrawal.

SW was seen by the drug and alcohol clinical nurse daily until he was cleared from the detox process on 16 July 2013.

On the 21 July 2013, he had a mental health assessment and reported the previously mentioned motor vehicle accident at age 12 with resultant head injury. A CT scan was conducted and showed no abnormalities or brain damage.

It was noted that SW was isolative with no social support or family. He denied any thoughts of self-harm in the past 12 months. He was cleared from Darcy Mental Health pod by the mental health registered nurse.

Group cell placement was recommended until cleared for normal cell placement by primary health on 26 August 2013.

SW remained at the MRRC until the 11 December 2013 when he was transferred to Wellington Correctional Facility.

Mental Health Assessment at Wellington Correctional Facility

At Wellington SW was seen by a nurse on 22 February 2014 and denied any thoughts of self-harm and was cleared for normal cell placement.

On the 2 April 2014 he had a psychological assessment. Psychiatrist Dr ASHKAR noted SW *had no history of serious mental illness. He was admitted to a psychiatric facility in a confused and disoriented state while living in Queensland which he explained - "I was drunk and off my head". He had experienced anxiety and depression at various times throughout his life, which he managed with alcohol. He had no history of self-harming or suicidal behaviour and he denied current suicidal ideation.*[3]

Further, the report states, "*SW responses* (to the clinical scales) *produced a high-range elevation on the alcohol dependence scale, consistent with his history of poorly controlled alcohol abuse , and low-range elevations on the Anxiety, Dysthymia* (Depression) *and drug dependence scales.*[4]

Prison Behaviour

On 29 April 2014 a review of SW's classification was conducted with the recommendation being C1 minimum security classification and transfer to Cessnock.

On 1 May 2014 he was transferred to Cessnock Correctional Centre. Initially he was housed in 'E' block, sharing a cell with another inmate.

On 24 May he was moved to 'B' block into cell 2111 by himself. It is unclear why this occurred, although there is no issue as he had been cleared for normal cell placement.

Interviews between the investigating Police and Correctional Officer (CO) SARGANT and SW's previous cell mate Chris NORRIE reveal SW was a quiet inmate who read books and kept to himself.[5] CO SARGANT states he did not see SW interacting with other inmates.[6]

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[3] Report of Dr Peter ASHKAR, para 8. Justice Health File

[4] Report of Dr Peter ASHKAR, para 16. Justice Health File

The case notes relating to SW supplied by Corrective Services NSW do not contain any reports of non-compliance or offences whilst in custody.

Demeanour Prior to Death

SW had not vocalised any suicidal ideation and had no current alerts at the time of his death.

An hour before lock in on 27 of May 2014 he approached CO SARGANT and requested a new laundry bag for his cell.[7] He displayed no actions out of the ordinary that evening and there were no concerns regarding his welfare.

Last Seen

SW was last seen at lock in when he was secured in his cell by Correctional Officers SARGANT and PARTINGTON at 6.55pm on 27 May 2014. SW was seen seated on his bed watching television.

Death discovered

At 6.20am on the 28 May 2014 CO BURNS attended cell 2111 for morning checks of inmates and discovered SW with a torn bed sheet around his neck, the other end attached to the ceiling light fixture. SW was in an upright position facing the bunk beds with his hands partially gripping the side of the top bunk.

The cell was locked before the correctional officers entered and there was no evidence found then or since that anyone had entered it since lock-in the previous evening.

SW was attended to by Correctional Officers and Justice Health Registered Nurses. No signs of life were detected, rigor mortis was present and resuscitation was not attempted. NSW Ambulance and police were notified.

Investigation

The death was thoroughly investigated by a specialist section of the New South Wales Police Force, the Corrective Services Investigation Unit. No evidence of any third party involvement was found.

Other prisons were interviewed and all expressed surprise that SW would apparently end his own life. However, all also said they were not aware of any enmity between the dead man and any other prisoner or prison officer such as might provide a motive for killing him.

An autopsy was performed by an experienced forensic pathologist. He found no injuries or signs of foul play. The marks on the body were consistent with those expected to be found in a self-administered hanging.

Conclusions

I am of the view that there is no evidence that any third party played any part in SW's death. The evidence overwhelmingly indicates that he intentionally took his own life.

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[5] Interview of inmate NORRIE, answer to Q15, page 3
[6] Interview of CO SARGANT, answer to Q20, page 3
[7] Ibid, answer to Q19, page 3

I am satisfied that the responsible officers within Corrective Services and Justice Health did all that could be expected to assess the risk of SW self-harming and that nothing that should have prompted intervention was identified.

I conclude that the death was unexpected and unforseen and that no actions or omissions by any person in authority contributed to it.

Findings required by s81 (1)

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

The identity of the deceased
The deceased person was SW.

Date of death
SW died on either 27 or 28 May 2014.

Place of death
He died Cessnock in New South Wales.

Cause of death
The cause of SW's death was hanging.

Manner of death
SW's death was intentionally self-inflicted while he was serving a sentence of imprisonment in the Cessnock Correctional Centre. I am satisfied that no third party played any role in his death and no actions or inactions of correctional staff or staff of Justice Health contributed to the death which was unforeseen and unexpected.

Recommendations

The Coroners Act in s82 authorises coroners presiding over inquests to make recommendations concerning matters connected with the death that are designed to contribute to public health and safety and or to prevent deaths occurring in similar circumstances in future.

The Corrective Services internal investigation drew attention to the fact that neither of the two officers who found SW had on their person a 911 rescue tool or cut-down knife which would have enabled them to immediately release the ligature from around his neck. In this case that caused no harm as SW had clearly been dead for some time. However, it is inconsistent with various sections of the *Operations Procedure Manual* and *Deputy Commissioners Memorandum* 2012/1.

I am advised that both policies have been recently updated and the following now applies to all custodial staff of Corrective Services NSW :

- Uniformed officers whose duties include inmate contact are to be issued with a 911 rescue tool at the commencement of duty;
- The 911 rescue tool must be carried at all times throughout the officer's shift; and
- Local operating procedures regarding the issue and return of the 911 rescue tool for each officer shift are to be implemented by General Managers at the correctional centres.

In those circumstances nothing would be achieved by my making any further comment about the issue.

The only other prevention issue which arises on the facts of this case relates to the accessibility of hanging points in the cell. That is an issue which has been well ventilated by coroners in other inquests. No further evidence was led in this inquest in relation to the issue.

I close this inquest.

M A Barnes
NSW State Coroner