CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Fenika Junior Tautuliu Fenika (Junior Fenika)
Hearing dates:	26 – 28 February 2018, 1 – 2 March 2018, 17 April 2018 and 1 June 2018
Date of findings:	13 July 2018
Place of findings:	State Coroner's Court - Glebe
Findings of:	**Deputy State Coroner Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody High Risk Management Centre (HRMCC) Mental health
File number:	2015/268972

Representation:	**Counsel Assisting the Coroner**: Simeon Beckett of Counsel instructed by Clara Potocki Crown Solicitor's Office **Counsel for the Family**: Rebekah Rodger of Counsel instructed by Duncan Fine National Justice Project **Counsel for the Commissioner of Corrective Services NSW**: Christine Melis of Counsel instructed by Janet de Casto Lopo Office of the General Counsel, NSW Department of Justice **Counsel for Correctional Officers** (**Mark Kuczynski, Barry Hockey, Wayne Lang, Trent Tapper, John Murfitt, Andrew Oberg and Susan McInnes):** Robert Reitano of Counsel instructed by Michael Jaloussis McNally Jones Staff Lawyers **Counsel for Correctional Officer (Timothy Price):** Tony Howell of Counsel instructed by Dominic Longhurst McNally Jones Staff Lawyers **Counsel for Justice Health & Forensic Mental Health Network**: Ragni Mathur of Counsel instructed by Les Sara Hicksons Lawyers **Legal representative for Registered Nurse Michael Harris:** Peta Kava NEW Law Pty Ltd **Counsel for Dr Sarah-Jane Spencer:** Tim Saunders of Counsel instructed by Nevena Brown Meridian Lawyers **Graham Beer (self-represented)**

Findings:	**Identity of deceased**: The deceased person was Fenika Junior Tautuliu Fenika ("Junior Fenika"). **Date of death**: 12 September 2015. **Place of death**: The High Risk Management Correctional Centre in Goulburn in NSW. **Cause of death:** The cause of death was massive blood loss caused by incised wounds of left upper extremity. **Manner of death:** Junior Fenika used a razor to cut himself and then used the intercom system in his cell at 9.17pm and 9.23pm to alert a Corrective Services Officer that he had done this. I am not able to determine his intentions at the time he cut himself. If Corrective Services Officers had responded appropriately to the intercom calls, it is likely that he would have received medical treatment and his death would have been prevented.

Recommendations:	**To the Minister for Corrections, the Minister for Health, Justice Health and Commissioner of Corrective Services NSW** 1. That CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide. **To Corrective Services New South Wales (CSNSW)** *Knock-Up System* 2. That steps be undertaken to improve the audio-quality of the Knock-up System at the High Risk Management Correctional Centre (HRMCC). 3. That the Local Operating Procedures at the HRMCC be amended to require a Corrective Service Officer, in the Control Room or elsewhere, who receives an unclear knock-up call to reverse knock-up the caller to clarify the reason for the knock-up. 4. That a Corrective Services Officer who receives a knock up call records the call, the action taken (if any) and the officers involved. 5. That all Corrective Services Officers at the HRMCC be provided with regular training on COPP and Local Operating Procedures including new Local Operating Procedure HRM/002. *Rovers* 6. That Rovers on C and B Watch enter the HRMCC deck and open the hatch to the external door of each cell to conduct a visual check on the welfare of the inmate at least once per Watch. That additional security support for the Rovers be provided, if necessary, in order to do so. 7. That Rovers on C and B Watch inspect the rear yards of cells at the HRMCC on their rounds and report anything unusual to the Night Senior, including the escape of blood or water from cells. *Access to Razors* 8. That CSNSW formally consult with a Justice Health Mental Health Nurse as to whether an inmate at the HRMCC should have access to razors, other sharps or obvious ligatures where the inmate has recently engaged in or threatened self-harm or suicide, or has been supervised by a Risk Intervention Team (RIT).

	Family Visits 9. That CSNSW streamline the process for approving visits for inmates in the HRMCC. **To Justice Health & Forensic Mental Health Network ("Justice Health") and CSNSW** 10. That CSNSW ensure that Justice Health are provided with: a) real time information about inmates in isolation at the HRMCC; b) appropriate access to inmates kept in isolation at the HRMCC by Justice Health staff; and c) access to telehealth facilities. and, on that basis, Justice Health are to amend Justice Health Policy 1.360 *Segregated Custody* to apply to those kept in isolation at the HRMCC and who have a mental illness, whether or not the patient is in segregation. **To Justice Health** 11. Where the treating psychiatrist has concluded that isolation or segregation is adversely affecting the mental illness of a patient at the HRMCC the treating clinician, by way of a formal notification process, brings to the attention of the General Manager of the HRMCC the effect of isolation on an inmate's mental health.

Orders:	Orders until further order that: 1. Those parts of the Coronial Brief of Evidence set out in the **attached** Schedule not be published under section 74(1)(b) of the *Coroner's Act 2009.* 2. Pursuant to section 65 of the *Coroner's Act 2009* access to the sensitive CCTV and crime scene photographs is restricted.

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The Coroners Act 2009 (NSW) 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 Fenika Junior Tautuliu Fenika (Junior Fenika).

Introduction

Fenika Junior Tautuliu Fenika is the formal name of the deceased. While he was known as Junior Togatuki while in custody his family have asked that he be known in this inquest as Junior Fenika. Junior Fenika ("Junior") was last seen alive at about 2.30pm on 11 September 2015 by correctional services officers performing their rounds at that time. He was being held in custody in the High Risk Management Correctional Centre ("HRMCC") within the Goulburn Correctional Facility. Tragically, Junior was found by correctional services officers at about 8.30am on 12 September 2015 in Cell 15 of Unit 7 of the HRMCC cold to the touch and unresponsive. He was confirmed deceased by a Justice Health nurse who attended the cell at about that time and then by a medical practitioner later that day. He was aged 24 years.

The Inquest

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow the Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and manner of their death was. The manner of a person's death their death means the circumstances surrounding their death and the events leading up to it. When someone is in custody, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* ("the Act") makes an inquest mandatory in cases where a person dies in custody. In such cases, the community has an expectation that the death will be properly and independently investigated.

The Evidence

Background

1. Junior (born on 26 December 1990) was a New Zealand citizen of Samoan descent who moved to Auburn North, NSW, Australia from Wellington, New Zealand with his family at a young age in 1996.

2. Both his parents, Fenika and Atagai Fenika, were Samoans and he had four other siblings. Junior had two older sisters, Jean and Sarah, a younger

brother, Rocky, and a younger sister, Gemini. The entire family spoke Samoan.

3. At the age of 13, while attending secondary school in Mt Druitt, Junior began to fall afoul of the law. He assaulted a local doctor and then resisted arrest by police.

4. Junior had a criminal history including predominantly offences of violence, and property offences. He was first charged and convicted on 16 September 2006 of an aggravated robbery which occurred when he was 14 years old. This was followed by an array of offences including having custody of a knife in a public place, assaults, affray, shoplifting, and aggravated robberies.

5. On 2 December 2008, Junior was housed at Kariong Juvenile Correctional Centre where he continued to commit offences of a violent nature against other inmates.

6. On 9 September 2009, he was sentenced to 6 years imprisonment with a non-parole period of 3 years and 2 months for an offence of Aggravated robbery with wounding/grievous bodily harm where he and 3 juvenile co-offenders punched, kicked and stomped on the victim until he fell unconscious and then robbed him of his possessions.

7. On 8 April 2010, Junior was transferred from Kariong Juvenile Correctional Centre to the Goulburn Correctional Facility to serve the remainder of his sentence in an adult correctional centre.

8. On 19 August 2010, he assaulted a correctional officer by punching him in the face then, on 11 February 2012 he assaulted another correctional officer by spitting in his face. On 29 July 2012, he again assaulted a corrective services officer inflicting actual bodily harm and he assaulted yet another corrective services officer on 27 December 2013.

9. In addition to attacking correctional officers, Junior was also involved in violent altercations with fellow inmates. On 6 June 2013, he attempted to assault another inmate using a weapon. On 21 January 2015, he punched another inmate in a scuffle. There were also several incidents where Junior threatened and shouted abuse to other inmates and corrective services staff.

10. Junior also committed various acts of arson and other disruptive acts such as flooding. Junior set fire to his cell on at least two occasions on 27 December 2012 and 20 July 2015. He is also noted to have flooded his cell on at least two occasions on 11 September 2013 and 18 November 2013.

11. A specialised management plan was implemented for Junior due to the high risk he presented to all corrective services staff. To facilitate any movement of Junior, the presence of at least four officers in full protective gear and armed with chemical munitions was required.

12. According to Justice Health records, Junior was charged on more than 30 occasions with internal offences. Consequently, he was often placed in segregation for prolonged periods.

13. On 13 January 2015, Junior's visa was cancelled pursuant to s. 501 of the *Migration Act 1958* (Cth) and he became a 'prohibited non-citizen'. He unsuccessfully appealed against the cancellation. Junior was adamant that he did not want to be deported to New Zealand and went on a hunger strike between 22 July 2015 and 31 July 2015 to protest his potential deportation.

14. Up until 6 August 2015, Junior understood that he would be housed at Villawood Detention Centre upon release from custody on 11 August 2015. On 6 August 2015 he received a telephone call from DIBP advising him that he will, instead, remain in custody with NSW Corrections after his full time sentence expires and will not be moved to Villawood Detention Centre based on information contained in Correctional Reports. When Junior asked what the reports were based on, DIBP stated they could not disclose that information.

15. On 7 August 2015, DIBP requested he be kept in his current place of custody as an alternative place of Immigration Detention.

16. On 11 August 2015, Junior's sentence expired but he was kept in custody at the HRMCC on behalf of the DIBP pending deportation back to New Zealand.

17. On 3 September 2015, Junior communicated to Immigration Officers who attended the HRMCC that he wished to be sent to Samoa instead.

18. Junior also suffered from drug and alcohol abuse and mental health issues. Junior self-reported that he began to binge drink to the point of "alcoholic blackouts" and smoke 7 grams of cannabis per day from the age of 12. He commenced using crystal methamphetamine from the age of 14 and heroin from the age of 18. As of May 2014, he expressed no interest in rehabilitation for drug and alcohol abuse.

19. With regard to his mental health, it is first noted that Junior has a possible or definite psychotic illness in Justice Health records on 16 October 2008, when he is 17 years old. Justice Health records note that Junior's father also suffered from mental illness for which he was medicated. Junior self-reported that he tried to hang himself in 2006 when drunk but changed his mind.

20. A psychiatric report dated 16 December 2013 noted that Junior presented as depressed and demoralised. On 19 May 2014, Professor Greenberg diagnosed him with polysubstance abuse, post-traumatic stress disorder, prolonged sensory deprivation, pseudo auditory hallucinations, paranoid ideation and an anti-social personality disorder that included difficulties with violence and aggression.

21. Junior was diagnosed with a psychotic disorder and was prescribed the daily anti-psychotic Amisulpride for schizophrenia, anti-depressant Mirtazipine, and Pizotifen for migraines, which he started on 1 November 2013. From 29 May

2015, Junior began to frequently refuse to take his regular medications, possibly on advice from his family, and this may have exacerbated his mental health issues. It was noted frequently on offender case notes and on his medical records that he refused to take his medication, and that even when he accepted it, he was unsupervised so that it could not be guaranteed he took it. It was noted that he therefore may have been unmedicated during this time.

22. On 6 August 2015, a psychiatric assessment noted that Junior presented with increased psychotic and depressive symptomology but he denied any thoughts of deliberate self-harm or thoughts of suicide.

23. By 13 August 2015, a psychiatry report noted he was suffering from auditory hallucinations and persecutory delusional beliefs such as his food being poisoned. By the 27 August 2015, this progressed to not wanting to talk about his immigration issues, his family or plans for the future.

24. On 3 September 2015, Junior used the inmate knock-up system 50-60 times claiming that correctional officers were plotting to kill him despite constant reassurances to the contrary. He communicated these persecutory suspicions to his family, specifically to his sister's (Jean Togatuki) partner, Mustufa Temur. He told Mr Temur that the government wanted him dead and would do away with him during the deportation process. According to Jean Togatuki, this call may have been made on 6 September 2015.

25. On 4 September 2015, Junior expressed thoughts of self-harm to the nursing staff and requested to be put into a safe cell. He was placed into an observation cell and a Risk Intervention Team ("RIT") review was commenced. The RIT was terminated on 5 September 2015 when Junior stated he no longer had thoughts of self-harm or suicidal ideation.

26. It appears however, that his mood fluctuated over the next few days. On 9 September 2015, CCTV footage of the rear yard to Junior's cell shows him writing, probably with soap, "GOD FORGIVE ME", "LOVE US ALL" and the date of "9.9.15" as well as placing a blue container on the concrete seat of the rear yard before standing in the yard appearing to be in deep contemplation. These factors may suggest Junior was potentially considering suicide by hanging himself from the steel cage of his rear yard. Eventually, he removed the blue container and used what appears to be a pillow case to remove what he had written on the ground. It is of note that the next day, on 10 September 2015, Junior specifically asked for the rear yard to his cell not to be opened which was considered unusual. Junior also tries to unsuccessfully call five members of his family.

The Fatal Incident

27. On 11 September 2015, Junior was housed in cell 15 of unit 7 in the HRMCC at Goulburn. It was noted he presented with "*a sullen and disengaged demeanour*" when he was seen in his segregation cell.

28. At about 2:02pm on that day, he was last seen by Assistant Superintendent David Smithson and Senior Correctional Officer David O'Connor who were performing final head and security checks of the prisoners in unit 7 while also distributing meals. They provided him with his meal then proceeded to lock and secure his cell.

29. CCTV footage shows that around 8:49pm, a light is turned on in Junior's cell and at 8:50pm, a dark substance appears at the bottom of the door to his rear yard which gradually increases in size along the door line. This substance is speculated to be blood. Crime scene photographs confirm this to be the case.

30. At [9:17pm], Junior activated the cell alarm system known as the "knock-up" and informed Correctional Officer Mark Kuczynski in the control room that he had "*slashed up*". Mr Kuczynski did not understand what was said by Junior and requested that he repeat himself. Mr Kuczynski was purportedly unable to hear anything the second time and ended the call. Following this call, Mr Kuczynski rang the rostered Rovers for the HRMCC, Correctional Officers Barry Hockey and Wayne Lang, who were in the meal room. He informed them of the knock-up from cell 15 of unit 7. He advised the fact that he did not understand what the inmate had said and requested that they attend the cell.

31. At 9:23pm, Junior called the control room again using the knock-up system and informed Mr Kuczynski he "*just slashed up*." However Mr Kuczyinski misunderstood this as Junior asking "*[w]here's my stuff?*" He told Junior that officers would come see him shortly. On neither occasion did Mr Kuczynski reverse call Junior to verify what had been said although it was possible to do so. It should be noted however, that it was not possible for Mr Kuczynski to replay the call to listen again for security reasons preventing corruption and deletion of data.

32. According to CCTV footage, Correctional Officers Hockey and Lang left the meal room at 9:40pm and they proceeded to the Officer's Station of unit 7 then looked through the glass towards cell 15 without actually approaching it. From this vantage point in the officers' station, it is not possible to see inside the cell. Mr Hockey noted that viewed from the Officer's Station, cell 15 was quiet and they could not observe anything out of the ordinary. Mr Hockey then called Mr Kuczynski from the Officer's Station and was informed by him that there had been a second knock-up where the inmate asked for his "stuff". He responded to Mr Kuczynski saying that it was already late at night and property enquiries would have to wait till the morning. Furthermore, as afternoon shift rovers, neither Mr Hockey nor Mr Lang had access to cell keys which would enable them to open the cells.

33. CCTV footage then shows at about 9:46pm, Correctional Officers Hockey and Lang left unit 7. Correctional Officers Hockey and Lang's actions were a breach of the Corrective Services' Operation Procedures Manual section 12.1.5 which stipulates that responding officers "*shall proceed directly to the cell to further investigate the call and if necessary respond to any serious incident*."

34. At a similar time, CCTV footage of the rear door to the cell depicts water being washed out of the cell with a mix of blood and water flowing out into the rear yard and further, onto the "sterile zone" which is a walkway for patrolling correctional officers. This flow of water continued until about 9:55pm at which point it appears the source was turned off. It is highly suggestive of Junior still being alive and able to move at this time.

35. At 10:52pm, CCTV footage from the same angle records Correctional Officers Graham Beer and Andrew Oberg walking over this mix of blood and water and paying no attention to it. Similarly, at 4:21am on 12 September 2015, Correctional Officers Trent Tapper and John Murfitt also walk across the wet area without paying it any attention.

36. At approximately 8:30am on 12 September 2015, Senior Correctional Officers Stephen McDonald, David Smithson and Daniel Hewson were conducting head checks in unit 7. When they opened the door to cell 15, they discovered Junior in a sitting position on his bed with his back against the shower bulkhead, a large gash observable on his left wrist and blood all over the cell.

37. The correctional officers responded immediately. Mr Smithson began banging on the inner cell door and yelling to try and get a response from Junior. Junior however, remained unresponsive. Meanwhile, Mr Hewson called for an immediate action team ("IAT"), medical staff and an ambulance by radio. Correctional Officer Paul Donohoe commenced an audio/video recording using a hand-held camera while Correctional Officer Joseph Stephens commenced the recording of a time log.

38. At about 8:33am, IAT staff arrived on the scene. They were followed shortly afterwards by Justice Health nurses Meredith Picker and Narrell McLaren. NSW Ambulance Officers also arrived at the unit but did not enter the cell.

39. At around 8:42am, after putting on personal protective equipment ("PPE") for blood spills, the IAT entered cell 15 and secured Junior by pressing a shield against him and grabbing both his arms. The IAT had also donned gas vests and one member was armed with a gas gun. It was noted that there was a laceration on Junior's left wrist which was about 5cm long and 2cm wide. He

was also cold and unresponsive. A razor blade was sighted on top of the bed near his left arm. Because he was cold to touch and his limbs were difficult to move, rigor mortis was suspected.

40. Written in blood on the wall opposite to Junior Fenika's cell wall were, among others, the words: "GOD KNOWS DA TRUTH", "AVA POROLE" and "ĀIGA LOVE YA's". The word "Āiga" appears to be Samoan connoting family. With the inmate secured, Justice Health nurses entered to examine him.

41. At approximately 8:47am, Junior was declared deceased by the Justice Health nurses. All correctives services and Justice Health staff exited the cell by 8:48am and a crime scene was declared.

42. Around 9:15am, Goulburn Police Detectives arrived and took over the duties of handling the crime scene.

43. As at 12 September 2015, "Self-harm" and "Mental Illness" remained active alerts on Junior's Inmate Profile. It is noted that on the P79A Report to the Coroner Form, it is recorded as 'unknown' whether the deceased had any mental health history, and that he was not being treated by any professional, including a psychiatrist or psychologist.

44. On 14 September 2015, an autopsy was performed by Dr Rebecca Irvine. In the Limited Autopsy Report for the Coroner dated 27 October 2015 Dr Irvine records Junior's direct cause of death as "*incised wounds of left upper extremity*". Superficial incised wounds were found on his left wrist, left dorsal hand and the right side of his neck but the fatal wound was in his left antecubital fossa (elbow crease) which cut into the medial cubital vein and was likely the source of the majority of the blood on scene. There was also a "*subscapular haematoma with superficial abrasion*" to the right side of his head.

45. Preserved blood samples taken from Junior were analysed, and his blood was found to contain 0.15mg/L of Amisulpride and <0.05 mg/L of Mirtazapine.

46. On 16 September 2015, the family of the deceased requested an inquest into Junior's death. Based on gaol call conversations between Mr Temur and Junior where the latter disclosed his beliefs that the government was trying to kill him and the abrasion on his head, his family have come to suspect foul play from prison staff being involved in his death. Ms Togatuki also cited that when Junior spoke to their parents on 8 September 2015, he showed no signs of suicidal ideation, asking for socks and underwear for the weekend. She also recalled speaking to Junior's counsellor who assured her that Junior

"*seemed very well and fine*". The family have taken issue with why they were not informed of Junior's mental illness in gaol.

47. A review of unbroken and time stamped CCTV footage from the day of Junior's death until his discovery however, does not show anyone else entering cell 15. This most probably rules out the direct involvement of any other individual in his death. It is the opinion of police that Junior's disclosures to Mr Temur of prison officers conspiring to murder him were the result of his mental illnesses.

Cause of death

48. The following items of evidence indicate that Junior died as a result of self-inflicted wounds:

    a. Junior told the officer in the Control Room that he had "*slashed up*";

    b. Junior was found with clear wounds to his left arm particularly at the wrist and cubital fossa;

    c. There was blood seen (on the CCTV) flowing from his cell on the evening of 11 September 2015;

    d. There was a considerable amount of blood painted on the walls of his cell, the shower recess and the floor of his cell;

    e. The wounds were caused by a sharp object;

    f. The pathologist (Dr Irvine) was of the opinion that he had compromised a major vein at the cubital foss and that he died as a result of incised wounds of his left upper extremity;

    g. A razor blade was found on the bed close to Junior's' body at about 8.42am on 12 September 2015; and

    h. CCTV footage of Unit 7 reveals that no person entered Cell 15 between when Junior was checked at 2.30pm on 11 September 2015 and 8.30am on 12 September 2015.

49. It was clear that in order to inflict the apparent wounds Junior must have cut himself with a razor a number of times in the same location on his arm. The evidence also indicated that the abrasion to Junior Fenika's head was superficial and was not causative of death.

50. On the evidence available to me I find that Junior died as a result of massive blood loss caused by self-inflicted wounds with a razor blade to the left side of his body (incised wounds of his left upper extremity).

Could Junior's death have been prevented?

51. Accident and Emergency Specialist, Dr John Vinen, gave evidence that it was likely that Junior was alive and moving at about 2.00am on 12 September 2015 based on the CCTV footage of the cell's rear yard.

52. Dr Vinen said that Junior could have been given medical treatment at any stage from when he first called the Control Room by knock-up between 9.00pm and 9.30pm on 11 September 2015. There was accordingly a window of about 5 hours from then until 2.00am when medical attention could have been given.

53. The medical treatment he needed was simple and involved first, applying pressure to the wound to stop the bleeding and then, second, transfer to a hospital. The initial treatment to staunch the bleeding could have been provided by correctional services officers.

54. Ambulance Officer Rod Whittle gave evidence that if an ambulance had been called at about 9.40pm on 11 September 2015 an ambulance would have been able to respond quickly to an emergency call at the HRMCC. He estimated an arrival time at the gaol of 5 to 7 minutes upon being called. He had been called to the gaol at Goulburn a number of times and was familiar with the process of accessing cells within the gaol. He estimated that it would take between 50 and 64 minutes from the time of the call for an ambulance to be dispatched, for ambulance officers to make their way to the patient, for the inmate to be attended to in the cell and for the patient to be transferred to Goulburn Hospital.

55. Dr Vinen was confident that if Junior had had medical attention to staunch the bleeding in a timely fashion then there was a high likelihood Junior would have achieved a complete recovery.

56. While a Directive from the Manager of Security required attendance of other officers or an IAT if entry to Junior's cell was required, that is unlikely to have delayed emergency access to the cell. On the morning of 12 September 2015 such a team was assembled in less than 15 minutes to enter Cell 15.

57. I accordingly find on the evidence available to me that Junior's death could have been prevented at any time up to the early hours of 12 September 2015 if Corrective Services officers were aware that he was in need of medical attention and either provided it themselves or called for an ambulance to attend.

58. The critical issue arising from this in the inquest was why no Correctional Services officer understood that medical assistance was required until Junior was discovered at about 8.30am on the morning of 12 September 2015. The focus of the inquest was accordingly on why Junior was not discovered bleeding from self-inflicted wounds notwithstanding that he had attempted twice to use the 'knock-up' system to alert correctional services officers to that fact. This issue is considered below.

Monitoring of inmates in Unit 7 of the HRMCC, the knock-up system and the rover's response

59. Correctional Services Officers at the HRMCC work on a three-watch system. The A Watch is approximately from 8.00am to 4.00pm; the C watch is from 4.00pm to 12.00am; and the B Watch from 12.00am to 8.00am. Sometimes officers start their watch earlier to allow for a handover. It is apparent that most meal, health, medication, programs, exercise, visits and telephone calls occur during the A watch. Breakfast is served approximately at the start of the A Watch and dinner at its conclusion about 2.30pm. Inmates are then at 'lock-in' from approximately 2.30pm. Medications are provided to inmates by a Justice Health nurse for the whole day at about 8.00am. As a result, the routine in the HRMCC is that inmates do not leave their cells and do not have contact with correctional services officers or others for about 16 hours in any given day.

60. The evidence revealed that the A Watch was when inmates had most interaction with officers and staff at the HRMCC. However, after dinner was served at the end of the A Watch there was no further direct contact with correctional officers. Officers on the C and then the B Watch had no direct contact with inmates. The only available mode of communication was via the 'knock-up' system which sounded first at the officers' station in Unit 7 and then in the Control Room if not answered within the first minute.

61. Security was provided by correctional services officers on the C and B Watch. The officers worked in pairs and spent half a shift "in the towers", monitoring the perimeter of the HRMCC from a high point. The other half of the shift was spent as "Rovers" monitoring Units 7, 8 and 9 in the HRMCC by undertaking visual inspections and patrols.

62. Roving duties were conducted at irregular intervals so that their rounds were not predictable. They included visual inspections of the units from the internal side and from the external side. On the internal side the inspection involved attending the monitoring room to observe the CCTV cameras and looking at

the cell doors from the officers' station without entering the "deck" (the area between the officers' station and the cell doors). In Unit 7 all cells have two secure doors as many if not all inmates are in segregation. The external door has a small hatch which allows an officer to see into the cell. The internal door has large clear windows in it to allow for easy visual inspection of the interior of the cell.

63. On the external side of the Unit each cell has an individual caged rear yard. The yards open onto an area known as the sterile zone between the rear of the cell yard cages and a perimeter wall. The area is similar to a bituminised street. Rovers are able to check rear yard doors but also look into individual yards many (but not all) of which are lit by a yellow light at night. The cages on the yards allow for the floor of the yard and the rear door of the cell to be visible from the sterile zone.

64. In between visual inspections officers were able to attend the meal room or access computers to undertake their work.

65. The procedures at the HRMCC at the time of Junior's death specifically prevented correctional services officers on duty from conducting either a physical or visual inspection of cells. The result was that inmates in Unit 7 were locked down from as early as 2.30pm until 8.30am the next day during which they had no contact with any correctional services officers and were not visually sighted by them.

66. The procedures also required that, on a C or B Watch, if two officers are to enter the deck then they must have a reason to do so and have notified the Night Senior. Secondly, they require a third officer to accompany them for such an entry being an officer who is tasked with holding the relevant keys and is to stand on the inside of the door in the officers' station 7 i.e. not on the deck. Of course, the Night Senior can accompany Rovers entering onto the deck. Otherwise Rovers are not to enter the deck.

67. It was evident that the deck was not considered to be safe by senior CSNSW officers notwithstanding that there was constant CCTV of the deck and it was clearly visible from the officers' station. Senior management gave evidence that additional staff would be required if the rovers were to be able to enter the deck. However, the evidence revealed that only one additional staff member was available to allow entry onto the deck at the changeover from the B Watch to the A Watch.

68. The issue was relevant because Junior could easily have been checked by the Rovers if they had looked through the hatch of the external door. The

reason no one did so was firstly because of the deck protocol described above and, secondly, the Night Senior was not contacted, contrary to the local operating procedures.

The 'knock-up' system

69. The evidence was that calls to the knock-up system were not clearly audible in the Control Room. The evidence from Officer Matthew Damaso was that the system was in working order but that the hard surface of cells often made knock-up calls inaudible. Mr Damaso was pessimistic about being able to improve the audio quality of the current system because of the cell audio conditions.

70. It was also evident that those in the Control Room had the option of using a 'speaker' and microphone system to communicate with the inmate or a telephone handset. Different officers preferred different methods. Officer Kuczynski relied on the speaker and microphone system and did not use the latter.

71. On 11 September 2015 Officer Kuczynski received two knock-up calls from Junior: the first at 9.17pm and the second at 9.23pm.

72. Officer Kuczynski did not understand what Junior said on the first knock-up call because he asked Junior to repeat what he said. He then asked Officer Hockey (who was in the meal room at the time) to attend and respond to the knock-up call.

73. On receiving an unclear call, the clear option available to Officer Kuczynski was to call Junior back and ask for the reason for the knock up call. This is a well-known technique and was known at the time as a 'reverse knock-up'. Officer Kuczynski failed to reverse knock-up Junior when the first call was unclear and that failure draws my criticism. If Officer Kuczynski had established that Junior had cut himself then, subject to any additional instructions from the Night Senior or the Manager of Security, he would have called for an ambulance to attend and treat Junior.

74. Officers at the HRMCC at the time, including senior officers, were required to inform the Night Senior if they received a knock-up call which "potentially" may have been an emergency. This was not well understood at the time by officers to include calls which were unclear. That was so, notwithstanding that the knock-up system is meant, in large part, for emergency calls and is the only form of communication that inmates have during a C and B Watch.

75. Officer Kuczynski did not understand this was required and did not wish to bother the Night Senior because he assumed he was busy. This was partly because the procedures were not clear, he had not been trained on the procedures and partly a failure of his judgment. If the Night Senior had been informed and as he had the available authority to enter the deck, he could have entered the deck at Unit 7 and visually inspected Cell 15 to determine what the knock-up was for. Such an action is likely to have led to an ambulance being called shortly after the 9.23pm call.

76. It is apparent that Officer Kuczynski did not clearly hear what Junior said during the second knock-up call. He told Junior that officers were on their way to him. Officer Kuczynski said that he (mis)interpreted Junior Fenika saying "*I've slashed up" as "Where's my stuff?*" which he assumed was a reference to his property.

77. Officer Kuczynski said that at the end of his shift he told the Night Senior Officer Timothy Price of the two knock-up calls for Junior. Officer Price recalls that he was told that the calls were about property and that the Rovers had been informed. As the matter was about property and should be dealt with by the A Watch, Officer Price considered no action was required.

78. While playing back such calls is one way in which to clarify an unclear call, it is a cumbersome one. The evidence indicated that the more efficient way is to reverse knock-up the inmate and to report the unclear call to the Night Senior for action. Clearly the instructions to those receiving knock-up calls needs to be clear and during the hearing senior management at the HRMCC took action to amend local operating procedures to ensure that where a knock-up call is unclear then it must be reported to the Night Senior.

79. According to the local operating procedures the Control Room officer should have informed the Night Senior as soon as the reason for the knock-up call was unclear. The Night Senior would then have an obligation to respond to the knock-up. The Night Senior is the key officer and the Control Room officer has a different function.

80. The evidence was that when an inmate is on a RIT and placed in an observation cell (which can be viewed in the Control Room) then the Control Room officer is informed of the RIT. Junior had been placed on a RIT on 4 September 2015 for a period of about 24 hours but was not on a RIT at the time of his death.

The Rovers' response

81. Officers Hockey and Lang were the responsible Rovers when Junior knocked up the Control Room. Officer Hockey was the more senior of the two and was a very experienced officer. Both were in the meal room at the HRMCC when Officer Kuczynski called to alert them to the knock-up from Junior.

82. Neither was in a hurry to attend Unit 7 to check on Junior and they did not leave the meal room for at least 15 minutes to do so. They were the only officers in the Meal Room and the Meal Room has a TV which, according to Officer Lang, was on at the time. Both had already eaten. The first round of the National Rugby League finals was on that night and the game was likely to have been concluding at about the time of Officer Kuczynski's call. The game was being watched in the neighbouring Correctional Centre by a number of guards on duty. In oral evidence neither Officer Hockey nor Lang said that they could remember watching the football. When asked what he was doing after he received the call and before leaving the Meal Room Officer Hockey said he was having a cup of tea and reading the paper.

83. Officer Kuczynski did not tell Officer Hockey during the (first) call that the knock-up was or may have been an emergency. As Officer Kuczynski was not aware what the call was for, it was at least possible that it was an emergency (as indeed it turned out to be). Officer Hockey was not told what the knock-up was for and, as Officer Kuczynski had not said it was an emergency he did not understand that it was an emergency situation.

84. Both Officers Hockey and Lang did leave the Meal Room and went to the officers' station in Unit 7. They conducted a visual inspection of the Unit including the deck and the cell doors including Cell 15 where Junior was incarcerated. They also smelt (presumably for smoke) and listened. Nothing unusual was seen, heard or smelt. As per operating procedures they did not enter the deck or approach the external door to Cell 15.

85. Facilities are provided at the Officers Station in Unit 7 for officers to reverse knock-up a cell. Officer Hockey did not reverse knock up Cell 15 from the officers' station and nor did Officer Lang. This was the obvious thing to do because no one knew why the knock-up call had been made and it was the easiest way to contact Junior. It was a clear failure by the two officers to take an obvious step and is deserving of censure. It is likely that if the call had been made that Junior would have told them he had slashed up and they could then have taken immediate action including informing the Night Senior and asking for an ambulance to be called.

86. Instead Officer Hockey called Officer Kuczynski and told him "*all was normal*". The check undertaken was inadequate for Officer Hockey to reach that conclusion. Crucially Officer Kuczynski then told Officer Hockey that Junior had "*asked for his stuff*". That was a dangerous conclusion for Officer Kuczynski to have reached based on his hearing of what he knew was an inaudible knock-up line from Junior. Officer Hockey accepted Officer Kuczynski's description that Junior had made a request for property, and he concluded that a response would have to wait until the next Monday. No attempt was made by either Officer Kuczynski or Officers Hockey or Lang to reverse knock-up Junior to clarify what he wanted. Officer Lang and Officer Hockey then left Unit 7. They had been in the officers' station for about 2 minutes.

87. In oral evidence Officer Hockey said that he did not reverse knock up Junior even though he knew the main reason there is a knock-up system is for emergencies. He said that Junior had a history of making nuisance calls but he agreed he did not know the particular knock-up call was a nuisance call. I do not accept that prior making of nuisance calls was a legitimate reason to ignore Junior Fenika's knock-up call on 11 September 2015. The knock-up system is the only available way for an inmate to communicate an emergency and the risks of not responding to a call are evidenced in this inquest.

88. As Officer Hockey acknowledged, the local operating procedures require that every knock-up call must be responded to. I find on the evidence available to me that Officers Hockey and Lang failed to properly respond to Junior's knock-up calls of 11 September 2015 contrary to local operating procedures.

89. I also find on the evidence available to me that if Officers Hockey or Lang had reverse knocked-up Junior from the officers' station in Unit 7 on 11 September 2015 it is likely they would have discovered that he was in need of medical attention and taken appropriate action.

90. Again it is likely that had they discovered that Junior had slashed up, the Night Senior would have been informed, an ambulance called and Junior would not have died.

Rovers - Water in the sterile zone

91. It was clear from CCTV tendered in the proceedings that there was water escaping from the rear of Cell 15 into the sterile zone where it then went into a drain. While CCTV footage of the rear yard reveals a dark substance visible in the water on the floor of the yard, it was not clear that the water was so coloured, or blood clearly visible, when the water flowed out of the yard into the sterile zone.

92. The reason for the water being flushed out of the cell was also not clear. It could have been because Junior wanted to signal those in the sterile zone, but he could also have yelled out to the officers and apparently did not. It may have been because he wanted to stop his blood from clotting by washing out the wounds. The reason need not ultimately be determined.

93. The next set of Rovers, Officers Beer and Oberg, can be seen walking in the sterile zone at 10.52pm. There is a considerable amount of water in the sterile zone which the officers walk through. Neither officer appears to examine the rear yard to Cell 15. Certainly neither officer reported the water or anything unusual about the yard. The rear yard to Cell 15 was well lit at the time and covered by CCTV. That footage reveals that there was a dark substance flowing out of the rear door to the cell which we now know was blood. It is reasonable to conclude that neither officer noticed the blood on the floor of the yard. No doubt that was because they were looking for unlocked yard gates and any obvious signs of escape. Neither was concerned about the water flowing from the cell as it was apparently a common occurrence and did not report it.

94. Officers Tapper and Murfitt undertook a similar patrol of the sterile zone at 4.21am and did not notice anything. The water from the rear of Cell 15 was far less than at 10.52pm.

95. There is merit in Rovers undertaking a closer visual inspection of yards to see whether there is anything unusual in those yards that might warrant further investigation. Closer inspection in this case may have led to further investigation of Junior's cell. The evidence did not reveal whether Rovers are required to inspect the ground of rear yards. There is merit in amending instructions to Rovers to inspect the rear yards of cells for anything unusual such as blood or water. Such an inspection could be undertaken without further additional time or resources required. Given that flowing water may be used to flood a cell and destroy clothing and bedding there is merit in reporting such an occurrence to the Night Senior for investigation, notwithstanding that its occurrence is commonplace.

Access to Razors

96. Junior used a common razor to inflict the wounds to the left side of his body that ultimately led to his death. The evidence was that no restriction had been placed on his access to such a razor for normal purposes.

97. The primary way for an inmate not to be given a razor is for Justice Health to advise Corrective Services NSW ("CSNSW") that there are concerns that the inmate will self-harm and should not have access to sharps. CSNSW may also form its own opinion.

98. Where the inmate has been placed on a RIT and is in an observation cell then CSNSW can be advised that an inmate not have access to such equipment. There are two ways for this to occur:

    a. Via the last page of the Mandatory Notification form for a RIT where discharge planning is set out; and

    b. Via a Health Problem Notification Form (from Justice Health to CSNSW).

99. Neither form appears to expressly require consideration of access to razors or other sharps, ligatures or clothing that could be used to make a ligature. While it would be possible to add such a warning (eg "not to have access to razors") there is nothing to prompt the Justice Health officer to give specific instructions. This may be because it is assumed that if the inmate is at risk of self-harm they should be placed in an observation cell.

100. Junior was subject to a RIT on two occasions in the month or so before his death: 23 July to 3 August 2015 and 4-5 September 2015. There is no mention on the last page of the first RIT ("Discharge to case Management and Progress Plan") that he should be prevented from having access to a razor. That was notwithstanding that he had been placed on a RIT because of concerns that he would self-harm by a hunger strike.

101. Similarly there is nothing on the last page of the second RIT. On 5 September 2015 he was to be returned to a "normal cell". That was notwithstanding that he had been placed on the RIT because he was having thoughts of self-harm.

102. The last Health Problem Notification Form, dated 6 August 2015, indicated to CSNSW officers that there was a high risk for aggression and violence with staff and that he should be given a "normal cell placement".

103. There is merit in amending both forms so that there is a requirement for Justice Health to nominate whether the inmate should have access to razors, sharps or obvious ligatures.

What policies, procedures and protections are in place to prevent access to sharps such as razor blades within Goulburn Correctional Centre?

104. The primary protection mechanism available at the HRMCC was that an inmate who was at risk of self-harm should be placed in an observation cell with camera monitoring. While Justice Health and CSNSW were in possession of information about self-harm, in the RIT process, neither took action to restrict Junior's access to a razor. There is merit in the amendments to the forms as indicated above, that there is a requirement for Justice Health to nominate whether the inmate should have access to razors, sharps or obvious ligatures.

Treatment of Junior's Mental Illness

105. Junior's mental health was monitored over a number of years by CSNSW psychologists and by Justice Health psychiatrists. On 18 November 2013 Dr AP McClure thought that he hints at PTSD, he was not suffering from depression and his affect was reactive. However, he did note that a prolonged regime of sensory deprivation placed him at risk of psychosis "*given his premorbid vulnerability*".

106. On 29 January 2014 Dr O'Dea recorded that Junior was suffering from auditory hallucinations and had already commenced using Amisulpride (an anti-psychotic medication). While he recorded that there was no acute psychosis he did record that there was a history of personality disorder, substance use disorder and ongoing problems with anger, aggression and psychosis. Dr O'Dea increased the amount of Amisulpride to 200mg per day. Junior was seen by a further psychiatrist on 22 April 2014 where the auditory hallucinations and paranoia were noted with a diagnosis of anti-social personality disorder, polysubstance abuse, PTSD and sensory deprivation. The Amisulpride was increased to 600mg daily. A similar diagnosis was made by Professor Greenberg on 19 May 2014.

107. On 21 October 2014 Junior was transferred to Parklea Correctional Centre to undertake the Violent Offenders Therapeutic Program ("VOTP"). He had frequent contact with psychologists during this time (about once per week). However, on 21 January 2015 he was involved in a violent incident with another inmate and was suspended from the VOTP. There was a further violent incident involving him on 16 February 2015 where the notes record that he was experiencing paranoid thoughts and he was "*psychotic … appeared to develop in context of prolonged segregation … general hypervigilance/paranoia*". Junior was transferred back to the HRMCC on 5 March 2015.

108. Shortly before Junior's transfer he was seen by psychiatrist Dr Fay who noted that he was suffering from psychosis which had developed in the context of prolonged segregation. Dr Fay noted an increase in paranoia and homicidal ideation, thought interference, general hypervigilance and paranoia. Dr Fay increased the Amisulpride to 800mg daily and added Quetiapine (another anti-psychotic) for sleep.

109. After his transfer back to the HRMCC Junior was not seen by a psychologist and did not see a psychiatrist until August 2015. The evidence did not reveal why Junior was not seen by a (CSNSW) psychologist between 5 March 2015 and the time of his death 6 months later.

110. Registered Nurse Michael Harris had seen Junior frequently while he was in Unit 7. During 2015 Junior was referred for mental health review in June 2015 (to which he did not attend) and was referred to a psychiatrist when he was placed on a RIT on 24 July 2015.

111. The Court heard evidence from Dr Sarah-Jane Spencer, who was the Deputy Clinical Director of Custodial Mental Health for Justice Health in 2015. Dr Spencer also provided clinical services to inmates including to Junior in August 2015. Dr Spencer was asked why Junior was not seen by a psychiatrist until August 2015. Dr Spencer indicated that she and Dr O'Dea provided psychiatric treatment to about 200 inmates at the HRMCC and adjacent Goulburn Correctional Centre, and visited about 24 times per year between the two of them. The notes record that Dr O'Dea attempted to see Junior in June 2015 but Junior refused the consultation. Otherwise the process relies on a Justice Health nurse to triage the patients and refer them, where considered necessary, to the visiting psychiatrist.

112. Dr Spencer saw Junior for an extended consultation on 6 August 2015. Her clinical notes stretched to 6 pages of detail. She noted his past history of psychotic symptoms in the context of prolonged segregation, paranoid ideation, and persecutory delusional beliefs. She noted that his behaviours had changed recently in the context of increasing isolation. She noted that he was presenting with an increase in psychotic depressive symptomatology and denying thoughts of self-harm or suicide. She increased his medication to 200 mg Amisulpride during the day with 800mg at night (a total of 1000mg per day) as well as Mirtazapine (an anti-depressant) 30mcg at night.

113. Junior's head sentence expired on 11 August 2015 and he had been told he would continue to be held at the HRMCC rather than be transferred to Villawood Immigration Detention Centre. The Justice Health and OIMS case notes record that this was markedly increasing his stress. On 13 August 2015 he said he would abandon his immigration appeal and accept deportation, although he then did not complete the relevant forms to do so. On 13 August 2015 he was involved in an altercation with Correctional Services Officer Troy, an IAT was called and both gas and force were used to restrain him. Dr Spencer attempted to see Junior that day but was denied access by CSNSW.

114. Dr Spencer returned on 27 August 2015 to see Junior but this time, she was only allowed to see him in the vestibule between his two cell doors with 3 or 4 correctional services officers standing within earshot. This was vastly inferior access compared to the caged room where the first consultation occurred without the presence of officers. The consultation was short and Junior was not forthcoming but did say that he was happy with the increase in medication. Dr Spencer hoped to review him in the future but no date was set.

Expert evidence of Drs Olav Nielssen and Adam Martin

115. Evidence was taken in conclave from two eminent psychiatrists well-experienced in the provision of psychiatric treatment in the custodial environment. While Dr Olav Nielssen was in private practice at the time of the hearing, Dr Adam Martin was an employee of Justice Health. Both were of the opinion that Junior was suffering from schizophrenia at the time of his death, Dr Martin also considered that he had a personality disorder. Both agreed that

his mental illness was accompanied by psychoses during 2015 in the nature of delusions of persecution and auditory hallucinations.

116. Both doctors agreed that placing Junior in segregation, as he was at the time of his death, precipitated, amplified and perpetuated his mental illness. This was because segregation for him meant an absence of human contact and sensory deprivation. There is ample medical literature to evidence the adverse effects of segregation on mental health.

117. At the time of Junior's death the following regime applied to his custody:

    a. He was in a one out cell – that is, by himself;

    b. He had access to a rear yard for limited periods during the A Watch, again by himself;

    c. He had access to phone calls on the deck of Unit 7, but was shackled and handcuffed when doing so, was accompanied by a number of guards so that calls could take place, and he stood in a locked cage to make those calls;

    d. He had a brief interaction with a mental health nurse every morning which included the dispensing of anti-psychotic medication to him;

    e. He had a limited number of consultations with a psychiatrist in 2015: with Dr Fay on 16 February 2015 and then with Dr Spencer for an extended consultation on 6 August 2015 and for a short cell door consultation on 27 August 2015;

    f. He had interactions with correctional services officers through his cell door for meals and other related matters but remained in his cell or yard;

    g. He had no other interaction with other inmates at all;

    h. He did not see any person, including a correctional services officer, during the C and B Watches, - a period of at least 16 hours.

118. Dr Nielssen was of the view that Junior's mental illness was not being adequately treated in the HRMCC because of the nature of the environment and lack of therapy. Dr Martin said he partially agreed. Junior was taking an anti-psychotic but had limited human contact and access to mental health services and was not responding to Amisulpride.

119. Both doctors agreed that a transfer to the MHSU was not possible for "*logistical reasons (non-clinical)*" but that clinically it was desirable to transfer him. Dr Martin said that once the logistical aspects were removed from the decision to transfer "*anyone in that situation would be better having more access to mental health services which were available either at Long Bay or in Silverwater*."

120. However, the doctors were split about whether transfer to Long Bay Hospital was possible. Dr Nielssen considered that transfer there was needed to properly treat his mental illness. Dr Martin said that transfer was not likely because Junior was taking his medication and there was a reasonable expectation that there would be a response to the medication he was taking and any decision should be made after a period of assessment.

121. Dr Martin indicated that the practice was to not refer patients to the Mental Health Screening Unit ("MHSU") unless the inmate was "*very unwell*". He said that this clinical decision was "*absolutely*" affected by the high demand and low supply of mental health beds. He continued that if there were more beds available then the threshold for transfer "*would be lowered*".

Access to the MHSU and Long Bay Prison Hospital

122. There are two facilities available for the treatment of those suffering from mental illness in the custodial environment: the Mental Health Screening Unit ("MHSU") at Silverwater (part of the Metropolitan Remand and Reception Centre) and the Long Bay Prison Hospital.

123. Currently there are 44 beds at the MHSU including 5 acute beds with camera cells (there were only 3 in 2015) and 30 sub-acute beds. At Long Bay Prison Hospital there are 40 available beds, five of which are camera cells in G Ward with further beds in E and F Wards. There are four consultant psychiatrists at each facility (two days a week each) with two full-time registrars who see patients daily. They are assisted by mental health nurses. Dr Spencer said that admission to those units delivers a better therapeutic outcome to treatment at the HRMCC due to the intensity and regularity of the treatment.

124. Dr Spencer's clinical notes do not reveal consideration of whether Junior should have been transferred to the MHSU or to Long Bay. She said that the "*only reason*" he was not transferred to the MHSU was due to his security classification. While she had never received a written direction to that effect, she said that the practice was that high-risk security inmates were not to be admitted to the MHSU. As that was her understanding, she did not actively consider his transfer.

125. In correspondence subsequently received from the legal representatives of CSNSW, it was asserted that there was "*no policy which prohibited or discouraged the transfer of mentally ill inmates who were high risk*" from the HRMCC to the MHSU. The correspondence also states *"arrangements would first have been required to be settled in relation to the staffing and level of security required for housing an inmate away from the HRMCC".* This proviso probably explains Dr Spencer's understanding. The practical effect of that statement is that such security arrangements were not in place at the relevant time to allow such a transfer.

126. I find on the evidence available to me that at the time of Junior's death, senior executives at Justice Health believed that CSNSW would not permit high-risk security inmates from being transferred from the HRMCC to the MHSU for

treatment, and accordingly no application was made to transfer Junior in 2015 to the MHSU for assessment and treatment.

127. The MHSU provides an important mental health treatment service in conjunction with mental health services provided at correctional centres and at Long Bay Prison Hospital (and Long Bay Forensic Hospital). There is high demand for the limited number of beds available at the MHSU and at Long Bay Prison Hospital for those suffering mental illness within the correctional system. It would be a substantial detriment to the rights of an inmate to obtain proper health care for them to be denied access to relevant treatment at the MHSU.

128. As CSNSW denies there is such a policy, there is merit in CSNSW and Justice Health establishing clear guidelines as to the circumstances under which a high-risk security inmate will be allowed to be transferred from the HRMCC to the MHSU. No doubt security concerns will need to be addressed but that should not stand in the way of providing proper medical treatment.

129. Dr Spencer said that high risk patients can be treated on an involuntary basis at G Ward at Long Bay Hospital but there are no facilities to treat them in the other wards where there are beds for voluntary patients. Dr Spencer said that the *Mental Health Act 2009* and clinical principles require that mentally ill patients be treated in the least restrictive way possible. That means a preference for treatment of an inmate patient on a voluntary basis rather than an involuntary basis. For high risk inmates, such as Junior, the only option was to treat him at the HRMCC on a voluntary basis or in G ward at Long Bay Prison Hospital as an involuntary patient. Dr Spencer's understanding of the availability of beds was shaped by her understanding of the CSNSW security practice which excluded referral to the MHSU.

130. Dr Spencer also indicated that there is also merit in the provision of 'telehealth' facilitates at the HRMCC because the inmate would have the opportunity to be seen more frequently by Justice Health clinicians. Dr Spencer came across as very professional and compassionate and was clearly affected by Junior's death.

Resources for mental health services

131. Both Drs Nielssen and Martin were clear that the demand for mental health beds was far higher than beds that are available. While a number of those with mental illness could lawfully be made involuntary patients there simply were not enough beds to accommodate them. Dr Nielssen said that he had published an article estimating that there are 5-7% of the prison population currently that are suffering from psychosis, being about 600 to 1000 people. While all those persons do not need to be treated at the MHSU or Long Bay Dr Martin estimated, based on his experience on the bed demand committee, that if there was double or triple the number of beds available they would be easily filled. He said there was merit in a properly planned and studied analysis of demand for mental health beds in the NSW correctional system.

132. As a result I recommend that a review be undertaken to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care.

Conclusion:

I find that Junior's death could have been prevented at any time up to the early hours of 12 September 2015 if corrective services officers were aware that he was in need of medical attention and either provided it themselves or called for an ambulance to attend.

I find that if corrective services officers had reverse knocked-up Junior from the control room or the officers' station in Unit 7 on 11 September 2015 it is likely they would have discovered that he was in need of medical attention and taken appropriate action.

I also find that consideration was not given to transferring Junior for mental health treatment to the Mental Health Screening Unit or to Long Bay Hospital because of high demand for and low supply of mental health beds for correctional inmates.

I am grateful to the interested parties and their legal representatives for the way they have approached this inquest. The fact that many of the recommendations proposed during this inquest have already been implemented or are in the process of being implemented is commendable.

In closing, I thank my counsel assisting, Mr Simeon Beckett and his instructing solicitors, Claudia Pendlebury and Clara Potocki from the Crown Solicitor's Office. Their expertise and professionalism, before and during this inquest has been of enormous assistance.

I also thank the officer in charge, Detective Sergeant Babb for carrying out his thorough investigation and preparation of the brief.

Finally, on behalf of the Court and personally, I offer my heartfelt condolences to those closest to Junior. The Fenika family displayed great dignity as they attended each day of this inquest, including three days in Goulburn. Junior's sister, Sarah spoke so beautifully about her brother in her family statement. She wanted the Court to know that Junior was a "loving and caring brother". It is clear that Junior's death has had a huge impact on them and will continue to. I thank them for their participation in this inquest.

Findings required by section 81(1) Coroners Act 2009:

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.

The identity of the deceased

The deceased person was Fenika Junior Tautuliu Fenika ("Junior Fenika").

Date of death

12 September 2015.

Place of death

The High Risk Management Correctional Centre in Goulburn, New South Wales.

Cause of death

The death was caused by massive blood loss caused by incised wounds of left upper extremity.

Manner of death

Junior Fenika used a razor to cut himself and then used the intercom system in his cell at 9.17pm and 9.23pm to alert a Corrective Services Officer that he had done this. I am not able to determine his intentions at the time he cut himself. If Corrective Services Officers had responded appropriately to the intercom calls, it is likely that he would have received medical treatment and his death would have been prevented.

Recommendations:

For the reasons stated, I make the following recommendations pursuant to section 82 Coroners Act 2009:

To the Minister for Corrections, the Minister for Health, Justice Health and Commissioner of Corrective Services NSW

1. That CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide.

To Corrective Services New South Wales (CSNSW)

Knock-Up System

1. That steps be undertaken to improve the audio-quality of the Knock-up System at the High Risk Management Correctional Centre (HRMCC).

2. That the Local Operating Procedures at the HRMCC be amended to require a Corrective Service Officer, in the Control Room or elsewhere, who receives an unclear knock-up call to reverse knock-up the caller to clarify the reason for the knock-up.

3. That a Corrective Services Officer who receives a knock up call records the call, the action taken (if any) and the officers involved.

4. That all Corrective Services Officers at the HRMCC be provided with regular training on COPP and Local Operating Procedures including new Local Operating Procedure HRM/002.

Rovers

5. That Rovers on C and B Watch enter the HRMCC deck and open the hatch to the external door of each cell to conduct a visual check on the welfare of the inmate at least once per Watch. That additional security support for the Rovers be provided, if necessary, in order to do so.

6. That Rovers on C and B Watch inspect the rear yards of cells at the HRMCC on their rounds and report anything unusual to the Night Senior, including the escape of blood or water from cells.

Access to Razors

7. That CSNSW formally consult with a Justice Health Mental Health Nurse as to whether an inmate at the HRMCC should have access to razors, other sharps or obvious ligatures where the inmate has recently engaged in or threatened self-harm or suicide, or has been supervised by a Risk Intervention Team (RIT).

Transfer of Inmates to the Mental Health Screening Unit

8. That sufficient security support be provided by CSNSW to allow for the transfer and admission of HRMCC inmates to the Mental Health Screening Unit at Silverwater for medical treatment of mental illness.

Family Visits

9. That CSNSW streamline the process for approving visits for inmates in the HRMCC.

To Justice Health & Forensic Mental Health Network ("Justice Health") and CSNSW

10. That CSNSW ensure that Justice Health are provided with:

    a) real time information about inmates in isolation at the HRMCC;

    b) appropriate access to inmates kept in isolation at the HRMCC; \ and

    c) access to telehealth facilities.

    and, on that basis, Justice Health are to amend Justice Health Policy 1.360 Segregated Custody to apply to those kept in isolation at the HRMCC and who have a mental illness, whether or not the patient is in segregation.

To Justice Health

11. Where the treating psychiatrist has concluded that isolation or segregation is adversely affecting the mental illness of a patient at the HRMCC the treating clinician, by way of a formal notification process, brings to the attention of the General Manager of the HRMCC the effect of isolation on an inmate's mental health.

I acknowledge that CSNSW and Justice Health have taken or propose to take appropriate steps to address many of these recommendations and they should be commended for this.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

13 July 2018