CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of [redacted] and [redacted]
Hearing dates:	27 August 2018 – 31 August 2018; 27 February 2019 – 1 March 2019
Date of findings:	4 July 2019
Place of findings:	Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody; Health Problem Notification Form (**"HPNF**"); treatment of acute mental illness in custody; and mental health.
File numbers:	2010/00435610 - Inquest into the death of [redacted] [redacted] 2012/00273783 – Inquest into the death of [redacted]

Representation:

Mr N Kelly, counsel assisting, instructed by Ms C Berry and Ms K McCrossin, Crown Solicitor's Office

Mr D Evenden, Legal Aid NSW, on behalf of BB [redacted]

Mr S Woods and Mr B Bradley, instructed by Mr L Sara, Hicksons Lawyers, on behalf of Justice Health & Forensic Mental Health Network

Mr M Lynch instructed by Ms M Nicolle and Ms C Darroch, Meridian Lawyers for Dr G Elliott and Dr S Spencer (in relation to preliminary application)

Ms H Bennett instructed by S McKinnon and B Holliday-O'Brien, Office of the General Counsel, on behalf of Corrective Services NSW, Assistant Superintendent S Tienstra, Ms C Cheung, Assistant Superintendent M Cullen, Assistant Superintendent S Lockwood and Mr J Evans

Mr M Byrne, New South Wales Nurses and Midwives' Association, on behalf of Mr M Rec and Ms A Munoz

Mr D Wright, Wright Lawyers and Associates, on behalf of Assistant Superintendent J Gill

Ms P Robertson, New South Wales Nurses and Midwives' Association, on behalf of Ms S Freeman

Mr R Weinstein, instructed by Ms G Peres da Costa, MDA National, on behalf of Dr B Dall

Non-publication orders:

1. That the following information contained in the brief of evidence tendered in the proceedings not be published under s. 74(1)(b) of the *Coroners Act 2009 (NSW)* ("the Act"):

    a. The names, addresses, phone numbers and other personal information that might identify:

        i. Any member of RP DJ MA and/or BB family; and

        ii. Any person who visited RP DJ MA and/or BB while in custody (other than legal representatives or visitors acting in a professional capacity).

    b. The names, personal information and Master Index Numbers ("MIN") of any persons in the custody of Corrective Services New South Wales ("CSNSW").

    c. Direct contact details of CSNSW Officers and Justice Health & Forensic Mental Health Network ("Justice Health") staff not otherwise publicly available.

    d. Any information which may tend to identify private contractors retained by CSNSW to undertake security and/or other like services.

    e. Any floor plans detailing the layout and/or design of CSNSW operated facilities.

    f. The following CSNSW Policies:

        i. The version of Operations Procedure Manual ('OPM') *'Section 13.3 RIT Protocols for the Management of Inmates at Risk of Self Harm or Suicide'* (2007) which has not been made publicly available;

        ii. OPM *'Section 13.3.2 Management of inmates at risk of suicide or self-harm in correctional centres'* (2017); and

        iii. Custodial Operations Policy and Procedures *'Section 3.7 Management of inmates at risk of self-harm or suicide'* (2017).

2. Pursuant to s. 65(4) of the Act, a notation be placed on the Court file that if an application is made under s. 65(2) of that Act for access to CSNSW documents or Justice Health documents on the Court file, that material shall not be provided until CSNSW and Justice Health has had an opportunity to make submissions in respect of that application.

3. There is a non-publication order pursuant to s. 74 of the Act preventing publication of the evidence taken and tendered in the preliminary hearing about BB participation by video link.

4. Pursuant to s. 74(1)(b) of the Act, there be no publication of any evidence of MA name or any other information that may tend to identify him, including his current status as a forensic patient, and the location of his current whereabouts.

5. Pursuant to s.74(1)(b) of the Act, there be no publication of any evidence of the name RP in relation to these proceedings.

6. Pursuant to s. 74(1)(b) of the Act, there be no publication of any evidence of BB name or any other information that may tend to identify him, including his current status as a forensic patient, and the location of his current whereabouts.

7. Pursuant to s.74(1)(b) of the Act, there be no publication of any evidence of the name DJ in relation to the proceedings.

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Introduction

1. This inquest[1] concerns two deaths which occurred at the Metropolitan Remand and Reception Centre (MRRC), which is a metropolitan prison at Silverwater, NSW.

2. DJ died on 1 September 2012 in cell 407 of Pod 16 Hamden Block at the MRRC.

3. RP died at some time between 3.25pm on 23 April 2010 and 6.15am on 24 April 2010 in cell 108 of Pod 10 of Fordwick Block at the MRRC.

4. A decision to hold their inquests together is based on the similarities in the manner of the deaths of DJ and RP Each man died in his cell after having been placed with an inmate suffering from an active schizophrenic illness. Each man died from injuries that had been inflicted upon him in circumstances where he had been unable to escape. It is clear in hindsight that the mental health of each of DJ and RP cellmates, at the relevant times, was such that they should not have been placed in a cell with another person. In this sense both tragic deaths were potentially preventable. The inquest sought to understand the cell placement decisions that were made in an attempt to ascertain whether there are ways of reducing the likelihood of future similar tragedy.

5. It is important to state at the outset that most deaths in custody are from natural disease or suicide.[2] Deaths from violent assault in prison are fortunately rare. It appears that NSW Coroners have not frequently grappled with the specific issues raised in this inquest.

6. I note that the families of DJ and RP were notified of these proceedings but had no wish to participate. Nevertheless, I offer them my sincere condolences. Their loss in such terrible circumstances is profound and ongoing.

[1] In the context of these findings I refer, at times, to the proceedings as an inquest, however in fact two inquests were heard together.

[2] The Court received evidence that statistics collected by the Australian Institute of Criminology, pursuant to the National Deaths in Custody Program, which has been running since 1992 following the Royal Commission into Aboriginal Deaths in Custody, indicate that:

- in the 2013-14 and 2014-15 financial years there were a total of 115 deaths in custody - of those 115 deaths, 27 were deemed to be due to self-inflicted causes (suicide) and then there was no indication of how many deaths were due to unlawful homicide; and
- in 2011-12 and 2012-13, there was a total of 95 deaths in custody - of those, 21 were indicated to be due to self-inflicted causes (suicide) and four were deemed to be due to unlawful homicide.

The role of the coroner

7. When a person dies in custody it is mandatory that an inquest is held.[3] The inquest must be conducted by a senior coroner.[4] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that they receive care of an appropriate standard. Their living conditions are similarly restricted and prison authorities are called upon to manage an array of inmates, taking into account their often disparate needs and requirements. Cell placement is an important decision and can impact on an inmate's state of mind and physical wellbeing. In this case, the cell placement decisions made contributed to the tragic death of two prisoners.

8. These inquests follow criminal and forensic health proceedings and thus occur well after the events under investigation. Given the time that has passed, it was necessary to keep in mind whether practices and procedures in place at the time, remain current today.

The evidence

9. The court took evidence over eight hearing days. The court also received extensive documentary material in eleven volumes. This material included witness statements, medical records, photographs and expert reports. While I do not intend to refer to all the material in detail in these findings, it has been comprehensively reviewed and assessed.

10. A list of issues was prepared before the proceedings commenced. The following questions arose in relation to RP death:
    a. What was the date of RP death?
    b. Was there a systemic failure within CSNSW and Justice Health to identify/diagnose MA mental illness and risk of harm to others, leading to his placement in a two-out cell with RP
    c. Was the determination by the Risk Assessment Intervention Team (RAIT) on 20 April 2010 to require MA to be in a two-out cell appropriate in the circumstances and on the basis of the information available to the RAIT at that time?

[3] Section 27 *Coroners Act 2009* (NSW)
[4] Section 23 *Coroners Act 2009* (NSW)

d. Was psychiatrist Dr Dall's assessment of MA on 22 April 2010 appropriate in the circumstances and on the basis of the information available to Dr Dall at that time?

e. To what extent was information about MA engagement with community mental health services available to Justice Health to inform decision-making about risk of harm to others and cell placement?

f. Is there a need for CSNSW and Justice Health intake and screening processes, including RAIT protocols, to place a greater emphasis on identifying and escalating disclosure of delusional beliefs or hallucinations by inmates?

g. When an inmate discloses delusional beliefs or hallucinations should CSNSW protocol, including RAIT protocol, mandate that such inmates be excluded from two-out cell placement until they have undergone an urgent psychiatric assessment for possible mental illness?

h. Is there a need for CSNSW and Justice Health intake and screening processes, including RAIT protocols, to place a greater emphasis on interrogating the risk of harm to others presented by individual inmates, including through self-reporting of delusion beliefs and hallucinations and otherwise?

11. The following questions arise in relation to DJ death:

a. Was there a systemic failure within CSNSW and Justice Health to treat BB mental illness and identify his risk of harm to others, leading to his placement in a two-out cell with DJ

b. Was the decision by the RAIT on 23 August 2012 to assess BB risk of harm to others as low appropriate in the circumstances and on the basis of the information available to the RAIT at that time?

c. Was the decision by the RAIT on 27 August 2012 to allow/require BB to be in a two-out cell appropriate in the circumstances and on the basis of the information available to the RAIT at that time?

d. Was psychiatrist, Dr Gordon Elliott's, assessment of BB on 27 August 2012 appropriate in the circumstances and on the basis of the information available to Dr Elliott at that time?

e. Was the decision by CSNSW officers to place BB in a cell with DJ appropriate in light of DJ being in custody for child-related sexual offences?

f. To what extent was information about BB engagement with and treatment by community mental health services available to Justice Health and

to CSNSW to inform assessments of and decision-making in relation to, his mental illness and its treatment, his risk of harm to others?

g. Did BB receive appropriate medical treatment by Justice Health?

h. Did the information-collecting practices of CSNSW and Justice Health, and their information-sharing practices, contribute to a failure to properly assess and treat BB mental illness and identify BB risk of harm to others?

12. These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallize the issues which are really at stake. For this reason, after dealing with the facts, I intend to distil my reasons fairly briefly under a small number of broad headings. The focus of the inquest became the systemic issues at play, rather than the many individual decsions made in relation to the medical and custodial management of DJ and RP cellmates prior to their tragic deaths. At the end of the day, while no individual is held out for any particular criticism, the system in which they worked is exposed as inadequate and in need of review.

The deaths under investigation – fact finding

13. In this inquest there was no dispute in relation to the identity of the deceased men, or to the date and place of their deaths. The medical cause of each death was also clear. For this reason the inquest focused on the manner of the deaths. In particular the decisions leading up to the violence and whether or not there was a way of predicting or preventing what occurred.

14. Counsel assisting prepared a concise summary of the extensive documentary evidence. The summary of evidence was circulated to the parties during the course of the inquest for consideration and comment, prior to finalisation. The document was a careful synopsis of the salient facts leading up to the deaths under investigation. I indicated to the parties that I intended to adopt it as the basis of my fact finding and urged comment or correction. I was alerted to no particular controversy. In my view what follows is an accurate and useful distillation of the tendered material.

15. I thank those assisting me for their hard work in the preparation of the following chronologies and on the final submission document on which I also rely heavily. I thank the various parties for their extensive written submissions and for the cooperative way the inquest was approached.

The death of RP

RP ***- Chronology***

16. RP was born on 12 July 1991.[5] At the time of RP arrest, he was residing with his mother and brother and unemployed[6].

17. On 19 April 2010, RP was arrested and charged with:
    a. Aggravated indecent assault;
    b. Assault with an act of indecency; and
    c. Armed robbery.[7]

18. On 19 April 2010, RP went before Liverpool Local Court and was refused bail.[8] RP matter was adjourned to 5 May 2010 at Liverpool Local Court for mention[9].

19. RP was received at the Metropolitan Remand and Reception Centre (**"MRRC"**) on remand from Liverpool Local Court on 20 April 2010.[10] RP had not previously been remanded in custody[11].

20. RP was assessed on 21 April 2010[12] and deemed suitable for normal placement.[13] On 22 April 2010, RP was allocated and placed into cell 108 of POD 10 of F Block, a "two man cell" that had been occupied by MA since 20 April 2010.[14]

MA

21. MA was born on 11 December 1991.[15] MA was 18 years old as at the date of RP death. MA reported that prior to his arrest, he had been unemployed and had lived alone in rented accommodation.[16]

22. Andrea Simpson, a registered mental health care nurse working for the Child and Adolescent Community Mental Health Service at Camperdown Mental Health Service, Sydney Local Health District ("**CAMHS"**), first had contact with MA and his family in September 2008.[17] Specifically, Ms Simpson received a phone call from Mr

[5] P79A Report of Death to the Coroner, dated 24 April 2010 at p. 1 (tab 1).
[6] NSW Police Facts Sheet, dated 19 April 2010 at p. 193 (tab 20A).
[7] NSW Police Facts Sheet, dated 19 April 2010 at p. 192 (tab 20A).
[8] Criminal History, dated 18 May 2010 at p. 10 (tab 20); P79A Report of Death to the Coroner, dated 24 April 2010 at p. 2 (tab 1).
[9] Remand Warrant dated 20 April 2010 (tab 27).
[10] Corrective Services NSW Investigation Report, dated 20 August 2010 at p. 4 (tab 58).
[11] Intake Screening Questionnaire prepared by R Danylenko dated 21 April 2010 at p 134 (tab 28).
[12] Intake Screening Questionnaire prepared by R Danylenko dated 21 April 2010 at p 134 (tab 28).
[13] Corrective Services NSW Investigation Report, dated 20 August 2010 at p. 6 (tab 58).
[14] Statement of Correctional Officer George Reed, dated 17 June 2010 at [6] (tab 10).
[15] NSW Police Facts Sheet, dated 24 April 2010 at p. 2 (tab 22).
[16] Report of Professor David Greenberg, dated 21 February 2011 at p. 2 (tab 35).
[17] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [5]-[6] (tab 6).

MA mother, ZK on 11 September 2008 during which ZK raised concerns about MA mental health and illicit substance use.[18]

23. Ms Simpson conducted an assessment of MA on 17 September 2008 and formed the clinical impression that MA was a young man with a probable history of post-traumatic stress disorder as a result of incidents experienced as a child as well as severe, angry and violent thoughts which he had acted upon.[19] Ms Simpson intended to discuss treatment options for MA with the CAMHS team and also offer support to MA through anger management and counselling.[20]

24. On 26 September 2008, MA mother again requested a home visit as her son's behaviour had not improved.[21] Ms Simpson attended the home of MA that afternoon but no person was home.[22] A number of further attempts were made by Ms Simpson to contact MA but these attempts were unsuccessful and on 5 November 2008 MA was discharged from CAMHS.[23]

25. Ms Simpson's next contact with MA and his family occurred on 15 April 2009 when Ms Simpson attended MA home, however, MA had left the house as he did not wish to speak with Ms Simpson.[24] Ms Simpson subsequently referred MA to the First Episode Psychosis service at Croydon Health Centre.[25] MA was referred to Trish Lloyd, an Occupational Therapist with the First Episode Psychosis Team.[26]

26. On 7 May 2009 Ms Lloyd telephoned MA mother.[27] During this conversation ZK provided a lengthy family history and indicated that MA had been abused by his father's family.[28] ZK expressed concerns regarding MA drug and alcohol use and noted that MA had been cruel to her cat, ultimately killing her cat.[29]

27. After numerous attempts by Ms Lloyd, MA attended the Croydon Health Centre on 29 May 2009. MA identified a number of issues including the following: paranoia; becoming angry or hostile when paranoid; and unable to identify what makes

[18] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [6] (tab 6).
[19] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [6] (tab 6).
[20] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [7] (tab 6).
[21] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [8] (tab 6).
[22] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [8] (tab 6).
[23] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [8] (tab 6).
[24] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [9] (tab 6).
[25] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [9] (tab 6).
[26] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [9]-[10] (tab 6).
[27] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [10] (tab 6).
[28] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [10] (tab 6).
[29] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [10] (tab 6).

him paranoid.[30] MA also disclosed that he had used illicit drugs including that he had been smoking ten cones of cannabis per week.[31]

28. On 10 June 2009, Ms Lloyd again saw MA identified anger as the main problem he required help with.[32] MA stated that he had experienced conflicting thoughts towards the cat and that he had a 'split personality' at the time.[33] Ms Lloyd's formulation was that MA was a 17 year old male with a significant history of physical abuse during his early childhood who had described features suggestive of dissociative symptoms but with no clear psychotic symptoms.[34] Ms Lloyd recorded that a risk existed of impulsive anger outbursts and noted a history of acting on impulse[35]. Ms Lloyd's intention for MA was for his case management to continue under the First Episode Team and for his mental state to be monitored with particular attention to MA psychotic and mood symptoms.[36] Ms Lloyd indicated that MA was not to commence medication at this stage.[37]

29. On 18 September 2009, MA was discharged from the First Episode Psychosis Team due to his non-engagement with the service and other services he had been referred to.[38] Ms Lloyd recorded in MA progress notes that at the time of discharge, MA had been monitored for three months and there were no psychotic symptoms evident.[39]

30. On 4 March 2010, ZK telephoned the First Episode Psychosis Team. The following entry, inter alia, was recorded in the progress notes by S.Villagran:

> *"*MA *↑ aggressive*
> MA *taking illicit substances*
> MA *behaviour towards her as ↑ threatening – she's moved out of her DOH, presently living with friends – afraid of* MA *and that he may hurt her".*

31. S.Villagran recorded that it had been determined that the First Episode Team would not engage MA in response to the concerns raised by ZK as this was more a legal and police matter.[40]

[30] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[31] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [12] (tab 6).
[32] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[33] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [15] (tab 6).
[34] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[35] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[36] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[37] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[38] Statement of Detective Senior Constable Sinclair, dated 11 December 2014 at [16]-[17] (tab 6).
[39] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).
[40] Sydney South West Area Mental Health Service Progress Notes dated 29 May 2009 (tab 34).

Charges and entry into custody

32. On 14 April 2010, MA was charged with attempted murder and wound person with intent to cause grievous bodily harm.[41] It was alleged that on 10 April 2010, MA had stabbed the victim – a neighbour – in the stomach.[42]

33. On 13 April 2010, MA participated in an electronic record of interview with NSW Police in which he admitted stabbing the victim in the stomach and stated that he was seeking revenge against the victim and that he had been unwillingly subjected to acts of violence and indecency committed by the victim and the victim's friends.[43]

34. MA later told a psychiatrist that he had been hearing voices. The alien voices told him that if he killed someone and sacrificed someone, he would go to paradise.[44]

35. At the time MA was arrested, he was on conditional bail for a break, enter and steal offence committed in February 2010 against the same victim.[45] His remaining criminal history comprised entries for: destroy or damage property (DV) and contravene prohibition/restriction in AVO (charge date: 20 January 2010); possess prohibited drug (charge date: 11 December 2009); and destroy or damage property (charge date: 27 October 2009).[46]

36. MA was remanded in custody by Burwood Local Court.[47] MA was to appear at Burwood Local Court, via video link, on 9 June 2010.[48]

37. The only time MA had spent in custody prior to being remanded in April 2010 was one night on 20 February 2010[49]. The New Inmate Lodgement & Special Instruction Sheet, completed on 14 April 2010 at 9:00 am, recorded that MA was suicidal and that it was his first time in custody and, in response to "other immediate management or placement issues including cell placement", recorded "RIT".[50]

[41] Facts Sheet, dated 14 April 2010 (tab 26).
[42] Facts Sheet, dated 14 April 2010 (tab 26).
[43] Facts Sheet, dated 14 April 2010 (tab 26).
[44] *R v* MA [2012] NSWSC 503 at [34]-[36] (tab 40).
[45] Facts Sheet, dated 14 April 2010 (tab 26).
[46] Criminal History dated 18 May 2010 (tab 23).
[47] Facts Sheet, dated 24 April 2010 at p. 3 (tab 22).
[48] Corrective Services NSW Investigation Report, dated 20 August 2010 at p. 136 (tab 58).
[49] Inmate profile document at p. 205 (tab 29); see also copies at p. 25 (tab 29) and p. 147 (tab 58)
[50] New Inmate Lodgement & Special Instruction Sheet, dated 14 April 2010 at p. 41 (tab 32); New Inmate Lodgement & Special Instruction Sheet, dated 14 April 2010 at p. 215 (tab 29). Please note that it appears that the information recorded in the New Inmate Lodgement & Special Instruction Sheet differs between the records of Justice Health and CSNSW (respectively).

Events of 14 April 2010 to 24 April 2010

38. At approximately 4:00pm on 14 April 2010, an "Inmate Identification & Observation Form" was completed.[51] The author of this Form indicated that the author considered MA [redacted] to be at risk of suicide.[52] The Inmate Identification & Observation Form recorded, in response to the question "have you received psychological/psychiatric treatment", that MA had previously had contact with "Ashfield - Trish Loyd"(sic)[53].

39. At approximately 8:00pm on 14 April 2010, Ms Anna Grigore, registered nurse, conducted a health reception screening assessment on MA[54] Ms Grigore formed the opinion that MA was "mentally unwell" based on his presentation and lack of responses during the assessment. She was unable to say he was suffering a mental illness.[55]

40. Ms Grigore completed a Health Problem Notification form[56]. The Health Problem Notification form advised that MA should be placed in a camera assessment cell for his safety due to the serious charges and to observe his mood and stability until he was reviewed by the RAIT.[57]

RAIT Assessment of 15 April 2010

41. On 15 April 2010, at approximately 9:20am, MA was assessed by the RAIT. The RAIT was comprised by Acting Assistant Superintendent Blacklock, Registered Nurse Skye Freeman and welfare officer, Joshua Evans.[58]

42. During the course of the RAIT, RN Freeman completed "Assessment Form A1".[59] In the history of community mental health contacts, RN Freeman recorded:

> *"anger mx → saw psychologist*
> *Mum organised it*
> *→stated helped a little".*

43. RN Freeman recorded MA current risk status, with respect to harm to others, as low.

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[51] Inmate Identification & Observation Form, dated 14 April 2010 at p. 217 and p.250 (tab 29); Please note that it appears that the Inmate Identification & Observation Form in the records of CSNSW is located at p. 217 and p. 250 (with neither version complete) whilst only page 4 of the Inmate Identification & Observation Form in the records of Justice Health.
[52] Inmate Identification & Observation Form, dated 14 April 2010 at p. 220 (tab 29).
[53] Inmate Identification & Observation Form, dated 14 April 2010 at p. 253 (tab 29).
[54] Statement of Anna Grigore, dated 17 November 2014 at [4] (tab 15).
[55] Statement of Anna Grigore, dated 17 November 2014 at [9] (tab 15).
[56] Statement of Anna Grigore, dated 17 November 2014 at [11] (tab 15).
[57] Statement of Anna Grigore, dated 17 November 2014 at [11] (tab 15).
[58] MRRC RAIT Management Plan, dated 15 April 2010, at p. 37 (tab 32); Statement Skye Freeman, dated 1 December 2014 at [5] (Tab 15A); Patient Administration Record (tab 32(i)).
[59] Assessment Form A1 dated 15 April 2010, at p 28 (tab 32).

44. MA was assessed by the RAIT as constituting a "medium" risk of harm to himself and as constituting a "low" risk of harm to, and from, others.[60] The RAIT recorded, in the M.R.R.C – R.A.I.T Management Plan, in response to the question regarding whether MA suffered from a "mental health problem", "no". The RAIT determined that MA

    a. was to remain on RIT;
    b. be subject to focused case management;
    c. be placed in a "safe cell"; and
    d. with respect to his daily routine, be "normal by day".[61]

45. Ms Freeman completed and signed a Health Problem Notification form, which was also signed by Acting Assistant Superintendent Blacklock as the DCS Receiving Custodial Officer.[62] The Health Problem Notification form advised:

    "maintain MNF. Normal by day. Safe cell at night".[63]

RAIT Assessment of 18 April 2010

46. On 18 April 2010, at approximately 10:40am, MA was assessed by the RAIT[64]. The RAIT comprised Acting Assistant Superintendent Izgun, Registered Nurse Ali-Reza Akbari-Sepehr and welfare officer Michelle Curran.[65]

47. MA was assessed by the RAIT as constituting a "medium" risk of harm to himself and as constituting a "low" risk of harm to, and from, others[66]. The RAIT determined that MA was:

    a. to remain on RIT;
    b. be subject to focused case management;
    c. be placed in a "safe cell"; and
    d. with respect to his daily routine, be "normal by day".[67]

48. In MA Justice Health records, Registered Nurse Akbari-Sepehr recorded the following:

    "odd behaviour. Denies any sign of mental illness. Non-convincing"[68]

    And

[60] MRRC RAIT Management Plan, dated 15 April 2010, at p. 37 (tab 32).
[61] MRRC RAIT Management Plan, dated 15 April 2010, at p. 37 (tab 32).
[62] Health Problem Notification Form dated 15 April 2010, at p 26 (tab 32).
[63] Health Problem Notification Form dated 15 April 2010, at p 26 (tab 32).
[64] Patient Administration Record (tab 32(i)).
[65] MRRC RAIT Management Plan, dated 18 April 2010, at p. 36 (Tab 32); Statement of Ali-Reza Akbari-Sepehr, dated 7 November 2014 (tab 16); Statement of Michelle Curran, dated 27 April 2010 (Tab 12E); Corrective Services NSW Case Notes, dated 18 April 2010, at p. 191 (tab 29).
[66] MRRC RAIT Management Plan, dated 18 April 2010, at p. 36 (tab 32).
[67] MRRC RAIT Management Plan, dated 18 April 2010, at p. 36 (tab 32).
[68] Hospital Note, dated 18 April 2010, at p 38 (tab 32).

"*hesitant to respond when asked … stated people has got the ability to read the others mind by telepathy when asked if he can do this refused to respond 'I don't know'*

… ↓ Risk of harm to others

Impression = not convincing ? Mental health issue"[69]

49. The RAIT did not record a response in the M.R.R.C – R.A.I.T Management Plan to the question regarding whether MA suffered from a "mental health problem". The Management Plan included a referral to psychology.[70] The Progress Notes record referral to a psychologist and to a psychiatrist[71]. This latter referral was not recorded on the M.R.R.C – R.A.I.T Management Plan. The referral was recorded in the Justice Health patient administration system on 18 April 2010 by Mr Ali-Reza Akbari-Sepehr.

Intake Screening Assessment of 18 April 2010

50. On 18 April 2010, at 4:20pm, Ms Vanya Wit conducted a CSNSW intake screening assessment of MA Ms Wit noted that MA was being managed by the RAIT and referred MA to psychology for anger management and to alcohol and other drug counselling for his alcohol and other drug issues[72]. Ms Wit recorded that, in response to the question "have you hurt others when stressed?", MA responded "I have been known to fight others when I am angry"[73]. Ms Wit also recorded that, in response to the question, "have you ever seen a counsellor or psychologist in custody or in the community?", MA responded "anger management a psychologist in the community".

RAIT Assessment of 20 April 2010

51. On 20 April 2010, at approximately 11:00am, MA was assessed by the RAIT[74]. The RAIT comprised Assistant Superintendent Lockwood, Registered Nurse Skye Freeman and welfare officer Joshua Evans[75].

52. During the course of this assessment, Mr Evans telephoned ZK on two occasions. Mr Evans' case notes record the following in relation to his telephone conversation with ZK

"call made to mother post-interview → mother reported he is normally emotionless and possibly depressed. Referred in the community to Croydon Youth team. Croydon Youth team inconsistently attended. Mother reported victim is 'improving',

[69] Progress Notes, undated, at p 16-17 (tab 32).
[70] MRRC RAIT Management Plan, dated 18 April 2010, at p. 36 (tab 32).
[71] Case Management File – [redacted] MA - Case Notes, dated 18 April 2010, at p. 195 (tab 29).
[72] Intake Screening Questionnaire, dated 18 April 2010, at p. 214 (tab 29).
[73] Intake Screening Questionnaire, dated 18 April 2010, at p. 214 (tab 29).
[74] Patient Administration Record (tab 32(i)).
[75] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).

'very well', 'stable'. Mother agreed to contact welfare staff prior to son if news of death of victim received. Mother reported nil hx of self harm acts known".[76]

53. The RAIT assessed [redacted] as a medium risk of harm to himself and at medium risk of harm from others and a low risk of harm to others.[77] The RAIT noted referrals in place for review by a psychologist and the mental health team.[78] With respect to whether [redacted] suffered from a "mental health problem", the RAIT noted that [redacted] was "to be assessed"[79]. No threat of self-harm or suicide was claimed.[80]

54. The RAIT determined to alter [redacted] cell placement from "safe cell" to "2 x out cell" until review on 20 May 2010.[81] [redacted] RIT status was terminated.[82]

55. Registered Nurse Freeman completed and both Ms Freeman and Assistant Superintendent Lockwood signed a Health Problem Notification form.[83]The Health Problem Notification form advised:

"Terminate MNF

Clear from Darcy by Mental Health and RAIT".[84]

56. In the "Mandatory Notification for Offenders 'At Risk' of Suicide or Self-Harm" form, signed by each member of the RAIT, it was noted that the reason for lowering the level of risk was *"Consistently denies self harm ideation".*[85]

57. In the CSNSW Case Notes, Mr Evans recorded under the notation "IMP": "*Low risk of self harm – constantly denies self harm ideation, evidence of developing insight into situation coping with NBD routine coping with possible depression, settled and cooperative".* In the Justice Health records, Registered Nurse Freeman recorded: "INP: *? H/O depression. Accepting of situation. Some situational distress but coping". Plan: terminate. 2 out. [?] psychology"*[86].

Telephone call to Joshua Evans by [redacted] on 21 April 2010

58. On 21 April 2010, [redacted] telephoned Mr Evans.[87] In a report following [redacted] death, dated 26 April 2010, Mr Evans noted the following:

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[76] Case Management File – [redacted] - Case Notes, dated 18 April 2010, at p. 188 (tab 29).
[77] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[78] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[79] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[80] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[81] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[82] MRRC RAIT Management Plan, dated 20 April 2010, at p. 35 (tab 32).
[83] Health Problem Notification Form dated 20 April 2010, at p 25 (tab 32).
[84] Health Problem Notification Form dated 20 April 2010, at p 25 (tab 32).
[85] Mandatory Notification for Offenders "At Risk" of Suicide or Self-Harm, dated 20 April 2010 at p. 43 (tab 32).
[86] Justice Health records at p. 19 (tab 32).
[87] Statement of Joshua Evans, dated 26 April 2010 at p. 180 (tab 12D).

'[redacted] expressed concerns for [redacted] capacity to cope given the situational issues and possible depression. [redacted] was reassured that services are available in custody to support [redacted] and was advised that a referral had been generated for a review to take place by a psychologist".[88]

Mental Health Review of 22 April 2010

59. On 22 April 2010, Dr Basem Dall, a psychiatrist conducted a mental health review of [redacted] at MRRC's clinic which Dr Dall described as being similar to an outpatient clinic at a hospital.[89] Dr Dall described the environment at the clinic as "quite a chaotic environment".[90] Whilst Dr Dall is unable to be certain regarding the material available for his review, Dr Dall states that he would only have been provided with the Justice Health file for the prisoner and no more. Further, he did not have access to the prisoner's other files with the NSW Department of Corrective Services (**"CSNSW"**).[91] Dr Dall states there was no referral document.[92] The referral document is contained in the Justice Health file.[93]

60. Dr Dall made the following entry in [redacted] progress notes[94]:

"Difficult to engage with

Denied any M(ental) H(ealth) problem

- *denied feeling depressed*
- *denied psychotic phenomena*

Says he found talking to M(ental) H(ealth) difficult

Engaged well [with] other inmates – no fears or concerns

M(ental) S(tate) E(xamination

[Reduced] eye contact, difficult to engage, self-care appropriate

Speech – low rate, quantity

Flat / restricted

No F(ormal) T(hought) disorder

No delusions

No hallucinations

Sleep [reduced]

Denied thoughts of D(eliberate) S(elf)-H(arm)/ Suicide

Impression

- *Adjustment Reaction [with] depressed mood*
- *Possible depression*

[88] Statement of Joshua Evans, dated 26 April 2010 at p. 180 (tab 12D).
[89] Statement of Dr Basem Dall, at p. [11] (tab 15B).
[90] Statement of Dr Basem Dall, at p. [9] (tab 15B).
[91] Statement of Dr Basem Dall, at p. [7] (tab 15B).
[92] Statement of Dr Basem Dall, at p. [11] (tab 15B).
[93] Justice Health Records at p. 38 (tab 32).
[94] Statement of Dr Basem Dall, at p. [11] (tab 15B).

Plan
[Review] in [one month]
Not for [medication] at present"

61. Dr Dall believes that he spent approximately 15-30 minutes with MA [95] Dr Dall did not prescribe any medication and his plan was for MA to be reviewed in one month.[96]

Transfer to Cell 108

62. On 20 April 2010, MA was placed into cell 108.[97] On 22 April 2010, RP was also allocated to cell 108.[98]

The afternoon of 23 April 2010 and the morning of 24 April 2010

63. At approximately 3:25pm on 23 April 2010 MA and the deceased were locked in their cell for the evening.[99]

64. The following morning at about 6:15am, Correctional Services Officers began their morning head count of inmates within Pod 10 of the Fordwick Wing.[100] At approximately 6:18am, Correctional Officer Fernando Alfonso opened the door to cell 108, and saw RP lying on his back on the floor and MA standing next to him.[101] Correctional Officer Alfonso asked MA "is he alright?" and MA replied "I bashed him", repeating that statement several times.[102]

65. MA was removed from the cell and placed in an isolation cell and nursing staff from Justice Health were contacted to attend to RP [103] The Fordwick Wing was placed into lockdown.[104] Ambulance officers attended the scene at 6:45am but were unable to revive RP [105] At 6:50am a crime scene was established.

66. At approximately 10:25am MA was placed under arrest and cautioned by police and later transferred to Auburn Police Station.[106]

67. MA participated in an electronically recorded interview with police.[107] He stated that, in the early hours of the morning when RP appeared to be asleep, he climbed

[95] Statement of Dr Basem Dall, at [14] (tab 15B).
[96] Justice Health Records, at p. 20 (Tab 32); Statement of Dr Basem Dall, at [16]-[17] (tab 15B).
[97] Statement of George Reed, dated 17 June 2010, at p.84 (tab 10).
[98] Statement of George Reed, dated 17 June 2010, at p.84 (tab 10).
[99] *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[100] *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[101] *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[102] *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[103] Police Facts Sheet, dated 18 May 2010, at p 4 (Tab 22); *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[104] P79A Report of Death to the Coroner, dated 24 April 2010 at p. 3 (tab 1).
[105] P79A Report of Death to the Coroner, dated 24 April 2010 at p. 3 (tab 1); Police Facts Sheet, dated 18 May 2010, at p 4 (tab 22); *R v* MA [2012] NSWSC 503 at [20] (tab 40).
[106] Police Facts Sheet, dated 18 May 2010, at p 4 (tab 22).

on to RP bed and commenced to "stomp" him with his feet.[108] RP awoke and attempted to defend himself, whereupon MA put his arm around RP neck and tried to choke him.[109] The two men fell to the floor, where MA continued to choke RP.[110] RP attempted to crawl away from MA and as he did so MA kicked him a number of times.[111] Eventually RP stopped moving.[112] He did not regain consciousness and died in the early hours of the morning.[113]

68. MA subsequently told forensic psychiatrists that he needed to kill RP in response to instructions from aliens that he needed to sacrifice someone in order to go to paradise.[114]

Events following the death of RP

MA illness

69. MA was subsequently diagnosed with a treatment resistant schizophrenic illness and was found to have been suffering from a serious mental illness at the time of RP death, with acute symptoms including persecutory and grandiose beliefs and auditory hallucinations.[115]

Post-mortem examination

70. An autopsy completed by Dr Brouwer on 25 April 2010 revealed extensive haemorrhage of the soft tissues of neck with fractures of the hyoid bone and cricoid cartilage.[116] The cause of death was recorded as fatal pressure to the neck.[117]

Criminal proceedings against MA

71. On 16 May 2012, MA was found not guilty of the murder of RP by reason of mental illness in accordance with s 38 of the *Mental Health (Forensic Provisions) Act 1990* after a judge-alone trial[118]*.* Pursuant to s 39(1) of the Act, MA was ordered to be detained in a correctional centre or at such place as may be determined from time to time by the Mental Health Review Tribunal until released by due process of law[119].

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[107] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[108] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[109] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[110] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[111] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[112] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[113] *R v* MA [2012] NSWSC 503 at [21] (tab 40).
[114] *R v* MA [2012] NSWSC 503 at [26] (tab 40).
[115] *R v* MA [2012] NSWSC 503 at [41] (tab 40).
[116] Autopsy Report for the Coroner, dated 25 April 2010, at p 20 (tab 3).
[117] Autopsy Report for the Coroner, dated 25 April 2010, at p 19 (tab 3).
[118] *R v* MA [2012] NSWSC 503 at [47] (tab 40).
[119] *R v* MA [2012] NSWSC 503 at [21] (tab 40).

The death of DJ

DJ - *Chronology*

72. DJ was born on 26 June 1963.[120]

73. In 2007, DJ was convicted of three counts of indecent assault, one count of assault and one count of committing an act of indecency.[121] At the time of these convictions, DJ went by the name GC[122] DJ was sentenced to a good behaviour bond which included a supervision order expiring on 14 February 2010.[123] On 20 July 2012, DJ was arrested and charged with:
    a. five counts of producing, disseminating or possessing child abuse material; and
    b. four counts of failing to comply with reporting obligations.[124]

74. Around 4:50pm on 20 July 2012, DJ was refused bail at Bankstown Police Station.[125]

75. At 8:20pm on 20 July 2012, DJ entered into the custody of CSNSW at the Parramatta Court Cells.[126] A Health Problem Notification Form (**"HPNF"**) was completed by Registered Nurse Soung Lee.[127] RN Lee noted that DJ may suffer from "developmental (unclear)". RN Lee also indicated that CSNSW Officers needed to undertake the following: "while in Parramatta Police Cells: RIT; 24 hours camera cell monitoring; R/V daily". Joseph Zelezniak completed a "NSW Department of Corrective Services – Incident Details" Form which noted that DJ had been placed on RIT because "inmate presents as mentally handicapped. Would not guarantee his own safety whilst in cells".[128]

76. On 21 July 2012, DJ appeared at the Parramatta Local Court where bail was refused and he was remanded in custody.[129] Later on 21 July 2012, DJ was transferred to the Penrith Court Cells.[130]

77. Around 6:00pm on 22 July 2012, DJ was transferred to the MRRC.[131]

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[120]P79A Report of Death to the Coroner (tab 1, p. 1).
[121]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [2] (tab 27, p. 178)
[122]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [2] (tab 27, p. 178)
[123]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [2] (tab 27, p. 178)
[124]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [1] and [3] (tab 27, p. 178); NSW Police Facts Sheet (tab 53, p. 557)
[125]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [3] (tab 27, p. 178); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, pp. 719-720)
[126]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [3] (tab 27, p. 178); Inmate Profile Document for DJ (tab 29, p. 288); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 721)
Health Problem Notification Form dated 20 July 2012 (tab 28, p.243)
[128] NSW Department of Corrective Services - Incident Details dated 20 July 2012 (tab 28, p 248).
[129]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [3] (tab 27, p. 178); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, pp. 733-734)
[130]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [4] (tab 27, p. 179); Inmate Profile Document for DJ (tab 29, p. 288); Report of Kerri Trafford dated 4 September 2012 (tab 42, p. 468)

78. Around 7:25pm on 22 July 2012, DJ was assessed by Ann Parker, a Welfare Officer employed by CSNSW.[132] Ms Parker determined DJ was possibly developmentally delayed and could be vulnerable to harm from others.[133] Ms Parker noted that an Risk Intervention Team (**"RIT"**) had been raised by Parramatta Local Court.[134]

79. Around 8:25pm on 22 July 2012, DJ was reviewed by Registered Nurse Janis Wood.[135] RN Wood completed a Health Problem Notification Form which stated DJ was subject to an RIT, possibly had epilepsy and was developmentally delayed.[136] The HPNF directed that DJ was to be placed in an assessment cell subject to 24 hour closed-circuit television monitoring.[137]

80. On 23 July 2012, DJ applied to be placed in protective custody.[138] Later on 23 July 2012, Direction Number MRR1115970 was made, which placed DJ on a Protection Limited Association (**"PRLA"**) status.[139]

81. On 24 July 2012, DJ was assessed by an RIT comprised of Assistant Superintendent Steven Tienstra, psychologist Rowena Friend and Clinical Nurse Consultant Marco Rec.[140] DJ was assessed to be a low risk of suicide and self-harm, and he was cleared from the RIT for a normal cell placement with a referral to psychology.[141]

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[131]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [4] (tab 27, p. 179); Inmate Profile Document for DJ (tab 29, p. 288); Housing Location History of DJ (tab 31, p. 290); Report of Kerri Trafford dated 4 September 2012 (tab 42, p. 468)

[132]*R v* BB [2014] NSWSC 1274 at [10] (tab 5, p. 30); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [60] (tab 27, p. 189); Report of Kerri Trafford dated 4 September 2012 (tab 42, p. 468); Report of Ann Parker dated 6 September 2012 (tab 42, p. 471); Statement of Ann Parker dated 12 December 2012 at [7]-[11] (tab 54, pp. 564-565); Transcript of evidence given by Ann Parker on 8 September 2014 (tab 55, p. 580)

[133]*R v* BB [2014] NSWSC 1274 at [10] (tab 5, p. 30); Report of Ann Parker dated 6 September 2012 (tab 42, p. 471); Statement of Ann Parker dated 12 December 2012 at [10] (tab 54, p. 565); Transcript of evidence given by Ann Parker on 8 September 2014 (tab 55, pp. 580-581)

[134]Intake Screening Questionnaire dated 22 July 2012 (tab 28, p. 270); *R v* BB [2014] NSWSC 1274 at [11] (tab 5, p. 30) and [130] (tab 5, p. 64); Report of Ann Parker dated 6 September 2012 (tab 42, p. 471)

[135]Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 747)

[136]Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 747)

[137]Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 747)

[138]Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 789)

[139]Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 785, p. 798, p. 800)

[140]*R v* BB [2014] NSWSC 1274 at [12] (tab 5, p. 30); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [66] (tab 27, pp. 190-191); Report of Kerri Trafford dated 4 September 2012 (tab 42, p. 468); Report of Assistant Superintendent Stephen Tienstra dated 15 September 2012 (tab 42, p. 472); Report of Michele Curran dated 6 September 2012 (tab 42, p. 473); Case Note Report dated 24 July 2012 (tab 42, p. 475); Case Note Reports for DJ (tab 43, p. 488-489); Statement of Assistant Superintendent Stephen Tienstra dated 12 November 2012 (tab 59, pp. 592-594); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 746); Statement of Rowena Friend dated 29 May 2016 (tab 75, pp. 840-842); Statement of Marco Rec dated 16 November 2012 (tab 86, pp. 908-909)

[141]*R v* BB [2014] NSWSC 1274 at [12] (tab 5, p. 30) and [130] (tab 5, p. 64); Report of Kerri Trafford dated 4 September 2012 (tab 42, p. 468); Report of Assistant Superintendent Stephen Tienstra dated 15 September 2012 (tab 42, p. 472); Report of Michele Curran dated 6 September 2012 (tab 42, p. 473); Case Note Reports for DJ (tab 43, p. 488-489); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 746 and pp. 791-795); Statement of Rowena Friend dated 29 may 2016 (tab 75, pp. 840-842)

82. DJ was housed in the Darcy Block of the MRRC from 22 July 2012 until 22 August 2012.[142]

83. On 30 July 2012, DJ PRLA status was renewed.[143]

84. On 17 August 2012, DJ was reviewed by psychologist Steven Barracosa.[144] Mr Barracosa assessed that DJ was a "low intermediate" risk of self-harm or suicide.[145] Mr Barracosa referred DJ for psychological follow-up to take place after DJ next court appearance.[146]

85. On 22 August 2012, DJ was moved to Cell 407 of Pod 16 of the Hamden Block at the MRRC.[147]

86. On 23 August 2012, DJ underwent assessment for initial classification.[148]

87. On 24 August 2012, the initial remand classification of B_U (Unsentenced B medium security) and RBP (remand bed placement) were approved for DJ [149]

88. On 29 August 2012, DJ was notified of his classification, and he signed an initial classification document.[150]

BB

Criminal history and mental health prior to 2012

89. BB was born on 16 February 1972.[151]

90. BB was first placed into custody on 28 October 1991, after being convicted of larceny and sentenced to seven days imprisonment for default of payment of a fine.[152] Mr

[142]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [7] (tab 27, p. 180); Housing Location History of DJ (tab 31, p. 290)
Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 787)
[144]Report of Steven Barracosa dated 11 October 2012 (tab 42, p. 476); Case Note Report dated 17 August 2012 (tab 42, p. 477); Case Note Reports for DJ (tab 43, p. 490); Statement of Steven Barracosa dated 12 November 2012 (tab 79, p. 868 (at [6]) and pp. 870-871)
[145]Report of Steven Barracosa dated 11 October 2012 (tab 42, p. 476); Case Note Report dated 17 August 2012 (tab 42, p. 477); Case Note Reports for DJ (tab 43, p. 490); Statement of Steven Barracosa dated 12 November 2012 (tab 79, pp. 870-871)
[146]Report of Steven Barracosa dated 11 October 2012 (tab 42, p. 476); Case Note Report dated 17 August 2012 (tab 42, p. 477); Case Note Reports for DJ (tab 43, p. 490); Statement of Steven Barracosa dated 12 November 2012 (tab 79, pp. 870-871)
[147]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [8] (tab 27, p. 180); Housing Location History of DJ (tab 31, p. 290); Prisoner Cell Register for Cell 407 (tab 32, p. 292)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [52] (tab 27, p. 188)
[149]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [52] (tab 27, p. 188); Inmate Profile Document for DJ (tab 29, p. 287); Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 776)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [52] (tab 27, p. 188)
[151]NSW Police Facts Sheet (tab 7, p. 82); Inmate Profile Document for BB (tab 33, p. 294)
[152]Convictions, Sentences and Appeals of BB (tab 49, p. 529)

BB had further periods in custody in 1993, 1999, 2005 and 2006 for a variety of offences and due to breach of parole.[153]

91. On 22 August 2008, BB was convicted of shoplifting and driving whilst disqualified.[154] For these offences, BB was sentenced to a total of twelve months imprisonment, with a non-parole period of eight months.[155] The non-parole period for these offences expired on 14 October 2008.[156]

92. On 13 October 2008, Dr Gordon Elliott, Staff Specialist Psychiatrist, Justice Health, wrote to the Admitting Doctor at Cumberland Hospital, noting that BB was being released from custody the following day.[157] In that letter, Dr Elliott stated:

> '*BB has a psychotic illness of probably five years duration in the context of methamphetamine abuse. His illness is characterized by an ever more elaborate, but non-bizarre delusional belief [his partner] is having an affair with a man named Michael who has contacts with the "Fourth Reich" motorcycle gang.* BB *believes that this man has also sexually abused one of his daughters. He insists that he has … heard Michael and [his partner] plotting to kill him.* BB *believes Michael has placed a $30 000 contract out on his life. He believes this contract has been offered to other inmates in the jail, surmising this from the demeanour and behaviour of those around him. He has admitted to me in the past that he has heard his cell mate plotting with other inmates to kill him. … I am concerned about the potential risk he poses to his partner when untreated, or to anyone else he perceives to be involved in the plot to harm him."*

93. On the same day, Dr Elliott certified under s 19 of the *Mental Health Act 2007*, that BB was mentally ill and that were reasonable grounds that temporary care, treatment or control were necessary for BB and others' protection from serious harm.[158] In Part 2 of the relevant form, Dr Elliott expressed the opinion that there were serious safety concerns arising from BB being taken to a mental health facility without the assistance of a police officer, because "he has been refusing treatment and has been violent to others based on delusional beliefs". BB appears to have been at Cumberland Hospital until 16 October 2008 but was discharged after being observed as being free of symptoms.[159]

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[153] Convictions, Sentences and Appeals of BB (tab 49)
[154] Convictions, Sentences and Appeals of BB (tab 49, p. 525)
[155] Convictions, Sentences and Appeals of BB (tab 49, p. 525)
[156] Convictions, Sentences and Appeals of BB (tab 49, p. 525)
[157] V3 T94 p. 1199
[158] V3 T94 p. 1201-1202
[159] Tab 105, p. 3174

94. A discharge summary from Graylands Hospital in Western Australia records that BB was admitted to Geraldton Hospital for four days in July 2009 and then to Broome Hospital on 18 July 2009, before being transferred to Graylands Hospital.[160] The circumstances of his admission to Broome (and then Graylands) Hospital are recorded as:

> *'BB called the police on the night of 18.07.09 saying 80 Coffin Cheaters were after him. He was hiding in the house though the police could not see anyone. On presentation at Broome Hospital he was frightened and distressed. He came into hospital with a large knife to defend himself, but this was taken from him for safety. He was talking to himself and seeing and hearing what others could not. His condition escalated on the second day of admission. He secretly stole three dinner knives, barricaded himself in the bedroom, was yelling and verbally aggressive. He refused to take medications. Police were called in for safety reasons. He was handcuffed and then sedated en route to Sir Charles Gardner Hospital for extubation before arriving at Graylands Hospital."*

95. BB was discharged from Graylands Hospital after he was "aggressive no more and was complying with medication", being, relevantly, Olanzapine and Suboxone.[161]

96. BB was admitted to Cumberland Hospital on 6 August 2009 where he remained until 17 December 2010.[162] Much of this admission appears to have been as an involuntary patient.[163] The reason for referral is recorded as "long history of schizophrenia … at least since 2007 delusional beliefs that 'bikies want to get him' … several psychiatric admissions". The recorded diagnosis was treatment resistant schizophrenia, polysubstance abuse and antisocial personality traits. The summary of care records:

> *"Numerous difficulties in managing him during rehabilitation – was transferred to Waratah Cottage (independent living) but barricaded his room at night believing bikies would kill him. On one occasion he kept a knife in his room to defend himself. Also reported auditory hallucinations of persecutors outside his cottage.*
>
> *He was commenced on Clozapine + dose optimised with improvement in his symptoms. …*
>
> *Currently his mental state is stable."*

97. When BB was discharged he was prescribed clozapine and buprenorphine.[164]

[160] Graylands Hospital discharge summary dated 5 August 2009 (tab 104, p. 2431)
[161] Graylands Hospital discharge summary dated 5 August 2009 (tab 104, p. 2432)
[162] Transfer/Discharge Summary dated 15 December 2010 (tab 105, p. 3173)
[163] See V5 T104 pp. 3116-3164
[164] Transfer/Discharge Summary dated 15 December 2010 (tab 105, p. 3173)

98. On 8 August 2011, BB was admitted involuntarily to Shellharbour Hospital,[165] with diagnoses of drug induced psychosis, malingering and antisocial personality disorder.[166] The circumstances of admission are described as:

> *"39 year old male patient who is unemployed, single and homeless with known forensic history and diagnosed paranoid schizophrenia non compliant was brought into the hospital by police. The patient presented himself to police with a knife in his hand and stated that he would kill his sister, brother in law and his ex-wife's partner. H/O recent discharge from the hospital as he was found wandering the street with a knife and his desire to kill the people mentioned above."*

99. BB was discharged from Shellharbour Hospital on 26 August 2011, with a plan to continue on Olanzapine, which had been started during his admission. [167]

100. BB was admitted to Cumberland Hospital on 30 August 2011.[168] The circumstances of the admission are recorded as:

> *"…was brought in by police under section 22 when he called the police for help. He told that he had been following by [indecipherable] they want to kill him. He was also found in possession of morphine and a knife. He kept the knife for his safety. He denied any thoughts of self harm. He has a background history of treatment resistant paranoid schizophrenia."*

101. BB was discharged on 14 September 2011, with a plan to continue on Amilsurpride and Diazepam. BB was also discharged from the Shoalhaven Community Mental Health Team on 22 September 2011,[169] however he had been admitted to the Homeless Outreach service on 15 September 2011.[170] The Discharge Summary from the Shoalhaven Community Mental Health Team identified BB as a potential aggression risk when acutely psychotic.

102. On 16 December 2011, BB was made subject to an order under s. 32(3)(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW), requiring him to comply with a treatment plan provided by Dr Joe Garside, a treating doctor at the Homeless Outreach service, dated 1 December 2011.[171] Dr Garside's treatment plan was in the form of a letter,[172] which included the following:

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[165] Discharge Referral Note (tab 101, p. 2223)
[166] Discharge Referral Note (tab 101, p. 2223)
[167] Discharge Referral Note (tab 101, p. 2223)
[168] Transfer/Discharge Summary (tab 105, p 3170)
[169] Discharge Summary (tab 101, p 2221)
[170] Transfer/Discharge Summary (tab 102, p. 2233)
[171] Justice Health Records of BB (tab 97, pp. 1723-1724)
[172] Justice Health Records of BB (tab 97, pp. 1721-1722)

"BB is suffering from schizophrenia. He was first unwell with psychotic symptoms in the 1990s. He was not formally diagnosed with schizophrenia until around 2007. He has had a number of admissions since. Typically he has presented with bizarre persecutory delusions about being followed, monitored with special devices and people having plans to harm him. He has responded to delusional ideas by being violent in the past. … [The antipsychotic amisulpride] has been continued and he has had a good response to it. He continues to have residual persecutory ideas but he is no longer agitated and he has been able to successfully reside in medium term homeless accommodation and find occasional labouring work."

103. On 16 February 2012, BB was admitted to Cumberland Hospital as a voluntary patient.[173] BB stated his treating psychiatrist had changed his medication, but was not available for a consultation. During this admission, BB became agitated and demanded Seroquel so was placed in the high care unit under the "mental health act". BB diagnosis was recorded as chronic paranoia, schizophrenia, ASPD, poly-substance abuse and non-compliance. BB was discharged on 17 February 2012 after his General Practitioner was contacted, with a plan to continue Amilsurpride as prescribed by Dr Garside and the General Practitioner.[174]

104. On 2 March 2012, BB was admitted to Cumberland Hospital .[175] During this admission, BB was made an involuntary patient due to his increasing agitation and threatening behaviour. He was commenced on Quetiapine and his mental state improved. BB was discharged on 14 March 2012 with a plan to remain on Quetiapine.[176]

105. BB was discharged from the Homeless Outreach service on 11 July 2012 after being transferred to the MRRC .[177]

Arrest on 5 June 2012

106. On 5 June 2012, BB was arrested and charged with the offence of robbery armed with an offensive weapon.[178] BB was refused bail at Blacktown Police Station.[179]

[173] Transfer/Discharge Summary (tab 105, p. 3168)
[174] Transfer/Discharge Summary (tab 105, p. 3169)
[175] Transfer/Discharge Summary (tab 105, p. 3166)
[176] Transfer/Discharge Summary (tab 105, p. 3167)
[177] Transfer/Discharge Summary (tab 102, p. 2233)
[178] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [118] (tab 27, p. 200); Case Management File for BB (tab 35, p. 409 and p. 413)
[179] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [118] (tab 27, p. 200); Inmate Profile Document for BB (tab 33, p. 298)

107. While in police custody, BB attended the Emergency Department of Nepean Hospital seeking medication for his chronic shoulder pain.[180] Transitional Nurse Practitioner Julie Eldridge wrote a letter noting BB had a past medical history of schizophrenia, and had been prescribed Oxycontin and Seroquel.[181]

108. Around 8:15pm on 5 June 2012, BB entered into the custody of CSNSW at the Penrith Court Cells.[182] A "New Inmate Lodgement & Special Instruction Sheet"[183] and "Inmate Identification & Observation Form"[184] was completed which noted that:
    a. BB required an Interview for Placement as a "previous SMAP inmate";
    b. BB possessed concerns about being placed in a Correctional Centre as a "previous SMAP inmate – association alerts"; and
    c. BB was taking oxycontin for his shoulder injury and had schizophrenia.

109. It appears that the Inmate Identification & Observation Form was only partially completed.

Events prior to reception into the MRRC

Mental Health Assessment on 6 June 2012

110. On 6 June 2012, Clinical Nurse Consultant John McCallum of Justice Health completed a Mental Health Assessment for BB[185]

111. The Mental Health Assessment completed by CNC McCallum states:

> "BB *presents as a man likely to be suffering from a psychotic illness. He currently manifests risk factors consistent with an elevated risk of harm to self and others*."[186]

112. The Mental Health Assessment completed by CNC McCallum states that CNC McCallum discussed BB with a consultant psychiatrist named Dr Zhang around 1:30pm on 6 June 2012.[187] In relation to this conversation, CNC McCallum wrote:

> *"Due to the nature of [BB charges we are unable to recommend an order under section 33 of the Mental Health (Forensic Provisions) Act 1990. However,* BB *presents as likely to be suffering from a psychotic illness.*

[180] Justice Health Records of BB (tab 97, p. 1679)
[181] Justice Health Records of BB (tab 97, p. 1679)
[182] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [118] (tab 27, p. 200); Inmate Profile Document for BB (tab 33, p. 298); Housing Location History of BB (tab 34, p. 305); Case Management File for BB (tab 35, pp. 417-418)
[183] New Inmate Lodgement & Special Instruction Sheet (tab 35, p. 417)
[184] Inmate Identification & Observation Form (tab 35, p. 418)
[185] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [121] (tab 27, p. 200); Case Management File for BB (tab 35, pp. 374-377); Justice Health Records for BB (tab 97, pp. 1802-1803 and pp. 1782-1789)
[186] Justice Health Records of BB (tab 97, p. 1783)
[187] Justice Health Records of BB (tab 97, p. 1782)

… BB has been placed on a mandatory notification as an 'At risk' inmate and will need urgent psychiatric review in custody."[188]

113. CNC McCallum completed a Mandatory Notification Form (**"MNF"**) and requested intervention from an RIT.[189]

Appearance at Penrith Local Court on 6 June 2012

114. BB appeared at the Penrith Local Court on 6 June 2012.[190] At this appearance, bail was refused and BB was remanded in custody.[191]

115. Apparently, the remand warrant issued on 6 June 2012 stated BB "*requires assessment and treatment for mental illness in custody*" and requested that he undergo a psychiatric assessment.[192]

Reception into the MRRC

Events of 6 June 2012

116. BB was transferred to the MRRC on 6 June 2012 following his appearance at the Penrith Local Court.[193] BB arrived at the MRRC around 7:00pm.[194]

117. At 8:20pm on 6 June 2012, BB completed an Intake Screening Questionnaire with Welfare Officer Ann Parker.[195] During this assessment, BB advised that he was suffering from paranoid schizophrenia and had not been medicated for some time.[196] Ms Parker noted that BB status was "IFP and RIT raised by Blacktown CC.[197]

118. At some time on 6 June 2012, a Justice Health "Reception Screening Tool" was completed.[198] In this form, it was noted that BB had been diagnosed with schizophrenia "age of (unintelligible). On & off RX. Conf RX 2/12 ago". The author ticked "patient at risk and placed on MNF/RIT".

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[188] Justice Health Records of BB (tab 97, p. 1782)
[189] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [121] (tab 27, p. 200); Case Management File for BB (tab 35, pp. 374-377); Justice Health Records of BB (tab 97, pp. 1802-1804
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [120] (tab 27, p. 200); Inmate Profile Document for BB (tab 33, p. 298)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [120] (tab 27, p. 200); Inmate Profile Document for BB (tab 33, p. 298)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [120] (tab 27, p. 200)
[193] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [122] (tab 27, p. 200); Inmate Profile Document for BB (tab 33, p. 298); Housing Location History of BB (tab 34, p. 305)
Housing Location History of BB (tab 34, p. 305)
[195] Case Management File for BB (tab 35, pp. 393-398); Report of Ann Parker dated 17 September 2012 (tab 50, p. 536); Statement of Ann Parker dated 12 December 2012 at [12]-[13] (tab 54, p. 565);
[196] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [122] (tab 27, p. 200); Case Management File for BB (tab 35, p. 393); Report of Ann Parker dated 17 September 2012 (tab 50, p. 536)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [122] (tab 27, p. 200); Report of Ann Parker dated 17 September 2012 (tab 50, p. 536)
[198] Justice Health Reception Screening Tool, dated 6 June 2012 (tab 97, p. 1806)

119. At 9:15pm on 6 June 2012, BB was assessed by Registered Nurse Jian Zhang of Justice Health.[199] RN Zhang completed a HPNF which directed that BB be placed in a safe cell until he was cleared by the RAIT and received a detoxification clearance.[200]

Events of 7 June 2012

120. On 7 June 2012, BB made an application to be placed on protection.[201] He was then subject to a Placement/Threat Assessment which recommended a Special Management Area Placement ("**SMAP"**) direction.[202] A SMAP direction was made later that day.[203]

121. At 11:23am on 7 June 2012, Registered Nurse Shirley Graham completed a HPNF which stated BB had been "cleared form detox" and was to remain in a group cell in the Darcy Block until he was seen by a mental health nurse.[204]

122. Also on 7 June 2012, BB was seen by an RAIT comprised of Assistant Superintendent Martin Cullen, psychologist Catherine Cheung and Clinical Nurse Consultant Marco Rec.[205] This RAIT terminated the MNF and directed that BB be placed in a normal cell.[206] BB was assessed as a "low" risk to himself, to others, and from others.[207] A HPNF was completed by RN Rec which stated "MNF terminated by RIT" and "normal cell placement; hold in Darcy until R/V by MHN"[208].

Events of 8-18 June 2012

123. On 8 June 2012, BB fell and sustained a small laceration on his forehead.[209]

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[199]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [122] (tab 27, p. 200); Case Management File of BB (tab 35, pp. 372-373); Justice Health Records of BB (tab 97, p. 1823)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [122] (tab 27, p. 200); Case Management File of BB (tab 35, pp. 372-373); Justice Health Records of BB (tab 97, p. 1823)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [123] (tab 27, p. 200); Case Management File for BB (tab 35, p. 390)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [123] (tab 27, p. 200); Case Management File for BB (tab 35, p. 382-389)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [123] (tab 27, p. 200); Case Management File for BB (tab 35, p. 362 and p. 364); Care in Placement Report for BB (tab 36, p. 428)
Case Management File for BB (tab 35, pp. 368-369); Justice Health Records of BB (tab 97, p. 1823)
[205]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [124] (tab 27, p. 201); Case Management File for BB (tab 35, pp. 379-380); Case Notes Report for BB (tab 44, p. 494); Justice Health Records of BB (tab 97, pp. 1818-1819); Report of Catherine Cheung dated 20 September 2012 (tab 50,p. 537); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539); Statement of Catherine Cheung dated 21 November 2012 (tab 76, p. 845 and p. 848)
[206]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [124] (tab 27, p. 201); Inmate Profile Document for BB (tab 33, p. 297); Case Management File for BB (tab 35, p. 307 and pp. 365-367 and p. 370); Case Notes Report for BB (tab 44, p. 494); Report of Catherine Cheung dated 20 September 2012 (tab 50,p. 537); Justice Health Records of BB (tab 97, p. 1818 and p. 1824); Statement of Catherine Cheung dated 21 November 2012 (tab 76, p. 845 and p. 848)
[207]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [124] (tab 27, p. 201); Case Management File for BB (tab 35, p. 367 and p. 370); Case Notes Report for BB (tab 44, p. 494); Report of Catherine Cheung dated 20 September 2012 (tab 50, p. 537); Justice Health Records of BB (tab 97, p. 1818); Statement of Catherine Cheung dated 21 November 2012 (tab 76, p. 845 and p. 848)
[208] Justice Health Problem Notification Form dated 7 June 2012 (tab 97, p. 1824)
[209]Justice Health Records of BB (tab 97, p. 1678)

124. On 9 June 2012, Registered Nurse Soung Lee completed a Mental Health Assessment of BB [210] RN Lee assessed BB overall level of risk of suicide and violence as "low".[211] RN Lee completed a HPNF which directed that BB should be held in the Darcy Block in a normal cell until he was reviewed by a psychiatrist.[212] RN Lee also completed a Consultation Sheet.[213] The Consultation Sheet noted BB had schizophrenia and requested that a doctor review his medication.[214]

125. On 12 June 2012, BB was reviewed by Forensic Psychiatrist Dr Sarah-Jane Spencer.[215] Dr Spencer documented the following plan for BB

> *"I will recommence quetiapine, I will titrate dose in light of recent fall in his cell ?secondary to hypotension.*
>
> *To put on waiting list for Mental Health Screening Unit please.*
>
> *One out cell placement in light of psychosis and aggression."*[216]

126. Also on 12 June 2012, Registered Nurse J. Nguyen completed a HPNF which stated BB had been cleared from the Darcy Block by a psychiatrist and was suitable to be placed in a one-out cell in Pod 19 or 20 of the Mental Health Screening Unit (**"MHSU"**).[217]

127. On 14 June 2012, Registered Nurse Natalie Boorer completed a HPNF which stated BB had been cleared from the Darcy Block by a psychiatrist and was suitable to be placed in a one-out cell in Pod 19 or 20 of the MHSU .[218]

Placement in the Mental Health Screening Unit (18 June 2012 – 26 July 2012)

128. On 18 June 2012, BB was admitted to the MHSU.[219]

129. At 2:19pm on 18 June 2012, Mental Health Nurse Donald Standring completed a HPNF which stated BB was to be placed in a normal cell in Pod 19 of the MHSU.[220]

130. At 8:46am on 19 June 2012, MHN Standring completed a HPNF which stated BB was to be placed in a one-out cell in Pod 19 of the MHSU.[221]

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[210] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [125] (tab 27, p. 201); Justice Health Records of BB (tab 97, pp. 1790-1797 and p. 1825)
Justice Health Records of BB (tab 97, p. 1791)
[212] Case management File for BB (tab 35, p. 363); Justice Health Records of BB (tab 97, p. 1825)
[213] Statement of Soung Lee dated 8 August 2016 (tab 85, pp. 903-905)
[214] Statement of Soung Lee dated 8 August 2016 (tab 85, pp. 903-905)
[215] Statement of Sarah-Jane Spencer dated 23 August 2016 at [5] (tab 93, p. 946)
[216] Statement of Sarah-Jane Spencer dated 23 August 2016 at [8] (tab 93, p. 950 and p. 957)
[217] Case Management File for BB (tab 35, pp. 360-361); Justice Health Records for BB (tab 97, p. 1827)
[218] Case Management File for BB (tab 35, p. 359); Reports of Michelle Curran dated 18 September 2012 (tab 50, pp. 544-546); Justice Health Records for BB (tab 97, p. 1828)
[219] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [125] (tab 27, p. 201); Justice Health Records of BB (tab 97, p. 1829)
Case Management File for BB (tab 35, p. 358); Justice Health Records of BB (tab 97, p. 1667)
[221] Case Management File for BB (tab 35, p. 357); Justice Health Records of BB (tab 97, p. 1667)

131. Also on 19 June 2012, Angela Carroll of Cumberland Hospital's Health Information and Records Service sent a fax to Justice Health at the MRRC containing discharge summaries for BB admissions to Cumberland Hospital in February and March 2012.[222]

132. On 20 June 2012, Dr Joe Garside and Deborah Burke from the Western Sydney Local Health Network Homeless Outreach Team set a fax to Justice Health at the MRRC containing their file for BB [223]

133. On 21 June 2012, Eileen Houston from Shellharbour Hospital's Medical Records Department sent a fax to Justice Health at the MRRC containing a discharge summary for BB admission to Shellharbour Hospital in August 2011.[224]

134. On 25 June 2012, psychologist Erin Minard completed an initial psychological assessment of BB [225] Ms Minard documented the following impression of BB

> *"Mentally unwell. Minimising symptoms. Long history of interpersonal difficulties. History of violence in custody. Long history of paranoid persecutory ideation – currently describes "realistic" paranoia. Currently non-compliant with medication".*[226]

135. Ms Minard documented in BB case notes that she had no immediate concerns, and that BB was a low risk of self-harm at the time of the interview.[227] Ms Minard also documented that further contact would be required to complete her assessment, and undertook to follow-up BB in approximately one week.[228]

136. On 5 July 2012, BB had a follow-up interview with Ms Minard.[229] Ms Minard documented in BB case notes that BB showed evidence of ongoing paranoia and was a low risk of self-harm at the time of their interview.[230] Ms Minard referred BB for psychological follow-up in the Hamden Block once he was discharged from the MHSU.[231]

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[222] Justice Health Records of BB (tab 97, pp. 1691-1696)
[223] Justice Health Records of BB (tab 97, pp. 1699-1725)
[224] Justice Health Records of BB (tab 97, pp. 1673-1677)
[225] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [127] (tab 27, p. 201); Case Notes Report for BB (tab 44, p. 496); Report of Michelle Curran dated 18 September 2012 (tab 50, p. 545)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [127] (tab 27, p. 201); Case Notes Report for BB (tab 44, p. 496)
Case Notes Report for BB (tab 44, p. 496)
[228] Case Notes Report for BB (tab 44, p. 496)
[229] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [128] (tab 27, p. 201); Case Notes Report for BB (tab 44, p. 498); Report of Michelle Curran dated 18 September 2012 (tab 50, p. 545)
Case Notes Report for BB (tab 44, p. 498)
[231] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [128] (tab 27, p. 201)

137. On 24 July 2012, BB was cleared by MHN Standring to be transferred from the MHSU to the Hamden Mental Health pods.[232]

138. Mental Health Nurse Standring completed an MHSU Discharge Management Plan dated 24 July 2012 which stated:
    a. BB had a history of violence in custody;
    b. BB had a history of non-compliance and intermittent use of medications;
    c. BB had schizophrenia and "*evidence of ongoing paranoia*";
    d. BB "*may pose risk to others when unwell*"; and
    e. BB was to be placed in a one-out cell.[233]

139. Mental Health Nurse Standring also completed an HPNF dated 24 July 2012 which stated:
    a. BB had been cleared from the MHSU by a psychiatrist;
    b. BB had mental health issues; and
    c. BB was to be placed in a one-out cell.[234]

Placement in Hamden Block (26 July 2012 – 20 August 2012)

140. On 26 July 2012, BB was transferred from the Mental Health Screening Unit to Pod 17 of the Hamden Block.[235]

141. On 27 July 2012, BB was transferred from Pod 17 to Pod 15 in the Hamden Block.[236]

142. On 31 July 2012, BB made a written application for a Protection Non-Association direction ("**PRNA"**).[237] The effect of a PRNA direction would have meant BB would not be required to associate with other inmates.[238] In his application, BB stated he "*would like to be placed on* [non-association] *as I fear for my safety on SMAP and don't wish to be placed on* [limited association] *with sex offenders*".[239]

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[232]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [129] (tab 27, p. 202); Case Management File for BB (tab 35, p. 307 and pp. 352-353); Justice Health Records for BB (tab 98, p. 1845); Justice Health Records of BB (tab 97, p. 1668, p. 1670)
[233]Case Management File for BB (tab 35, pp. 354-356); Justice Health Records of BB (tab 97, pp. 1670-1672)
[234]Case Management File for BB (tab 35, p. 352)
[235]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [129] (tab 27, p. 202); Case Management File for BB (tab 35, p. 307)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [129] (tab 27, p. 202)
[237]Case Management File for BB (tab 35. pp. 350-351)
[238]*R v* BB [2014] NSWSC 1274 at [15] (tab 5, p. 31); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [130] (tab 27, p. 202);
[239]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [131] (tab 27, p. 202); Case Management File for BB (tab 35. p. 350)

143. On 1 August 2012, BB PRNA application was considered by Assistant Superintendents Jasdip Gill and Martin Cullen.[240] BB application for a PRNA direction was refused.[241] However, Assistant Superintendent Gill wrote on the application that BB should be placed in a one-out cell and exercised alone, however noted that if "*this doesn't work inmate to be changed to LA/NA after threat assessment*".[242] Assistant Superintendent Gill also noted on the application that BB "*has mental health issues and maybe* [sic] *paranoid*".[243] Assistant Superintendent Cullen, who was then acting as the Area Manager, endorsed Assistant Superintendent Gill's plan and recommended that BB be monitored for the following two days and reviewed on 3 August 2012.[244]

144. Also on 1 August 2012, a reception committee convened for BB [245] The reception committee included Assistant Superintendent Gill and Welfare Officer Deborah Moffitt.[246] BB was classified as "E2U Unsentenced 'E'" and RBP (remand bed placement).[247] Assistant Superintendent Gill recommended that BB be managed in accordance with the plan which he had written on BB PRNA application.[248]

145. On 6 August 2012, BB was due to see psychologist Alita Caon.[249] However, BB refused to leave his cell.[250]

[240] *R v* BB [2014] NSWSC 1274 at [16] (tab 5, pp. 31-32); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [131] (tab 27, p. 202); Case Management File for BB (tab 35. p. 351); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539); Transcript of evidence given by Assistant Superintendent Jasdip Gill on 8 September 2014 (tab 66, p. 620 and p. 623)

[241] *R v* BB [2014] NSWSC 1274 at [16] (tab 5, p. 32); Case Management File for BB (tab 35. p. 351)

[242] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [131] (tab 27, p. 202); Case Management File for BB (tab 35. p. 351); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [131] (tab 27, p. 202); Case Management File for BB (tab 35. p. 351)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [131] and [134] (tab 27, p. 202-203); Case Management File for BB (tab 35. p. 351); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)

[245] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [132] (tab 27, p. 202); Case Note Report for BB dated 1 August 2012 (tab 50, p. 543)

R v BB [2014] NSWSC 1274 at [16] (tab 5, pp. 31-32); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [133] (tab 27, p. 202); Case Management File for BB (tab 35, pp. 319-320); Report of Assistant Superintendent Jasdip Gill dated 19 September 2012 (tab 38, p. 433); Case Note Report for BB dated 1 August 2012 (tab 50, p. 543); Statement of Deborah Moffit dated 20 November 2012 at [11] (tab 64, pp. 614-616); Statement of Assistant Superintendent Jasdip Gill (tab 65, pp. 617-619); Transcript of evidence given by Assistant Superintendent Jasdip Gill on 8 September 2014 (tab 66, p. 620)

[247] Inmate Profile Document for BB (tab 33, p. 294); Case Management File of BB (tab 35, p. 320 and 322); Report of Assistant Superintendent Jasdip Gill dated 19 September 2012 (tab 38, p. 433); Statement of Assistant Superintendent Jasdip Gill (tab 65, pp. 617-619); Transcript of evidence given by Assistant Superintendent Jasdip Gill on 8 September 2014 (tab 66, p. 620)

[248] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [133] (tab 27, p. 202); Report of Assistant Superintendent Jasdip Gill dated 19 September 2012 (tab 38, p. 433); Statement of Assistant Superintendent Jasdip Gill (tab 65, pp. 617-619); Transcript of evidence given by Assistant Superintendent Jasdip Gill on 8 September 2014 (tab 66, p. 621)

[249] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [135] (tab 27, p. 203); Case Notes Report for BB (tab 44, p. 505)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [135] (tab 27, p. 203); Case Notes Report for BB (tab 44, p. 505)

Placement in Darcy Block (20 August 2012 – 30 August 2012)

Threat of self-harm on 20 August 2012

146. On 20 August 2012, BB spoke to Senior Correctional Officer Peter Wilson and threatened to harm himself.[251] BB told Senior Correctional Officer Wilson that a number of inmates were "*out to 'get' him*".[252] BB asked Senior Correctional Officer Wilson if he could be moved to Pod 16 of Hamden Block.[253]

147. Senior Correctional Officer Wilson signed an MNF dated 20 August 2012, which was also partially completed by RN Guilfoyle, which requested intervention from an RAIT team.[254]

148. RN Guilfoyle completed and signed a HPNF, which was also signed by Senior Correctional Officer Wilson as the DCS Receiving Custodial Officer which stated BB

    a. Had threatened self-harm and been placed on RIT;
    b. Had mental health issues;
    c. Had a history of impulsive self-harm; and
    d. Could not guarantee his own safety.

149. RN Guilfoyle directed that BB be placed in a safe cell.[255]

RAIT Review on 21 August 2012

150. On 21 August 2012, BB was to be reviewed by an RAIT.[256] However, BB refused to leave his cell to participate in the interview.[257]

151. Assistant Superintendent Stephen Tienstra, Welfare Officer Raquel Rodriguez and Registered Nurse Barbara Sullivan signed an RAIT Management Plan dated 21 August 2012 which noted that BB "*refused to participate in interview – refused to leave cell*", and stated:

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[251]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [136] (tab 27, p. 203); Case Management File for BB (tab 35, p. 349); Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 440); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 638 and p. 641)

[252]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [136] (tab 27, p. 203); Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 440); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 638)

[253]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [136] (tab 27, p. 203); Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 440); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 638)

[254]Case Management File for BB (tab 35, pp. 346-347)

[255]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [136] (tab 27, p. 203); Case Management File for BB (tab 35, p. 348); Justice Health Records for BB (tab 97, p. 1821); Justice Health Records for BB (tab 98, p. 1844); Statement of Patricia Guilfoyle dated 26 April 2015 (tab 90, p. 926-927)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [137] (tab 27, p. 203); Case Notes Report for BB (tab 44, p. 505); Report of Assistant Superintendent Stephen Tienstra dated 15 September 2012 (tab 50, p. 547)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [137] (tab 27, p. 203); Case Management File for BB (tab 35, p. 343); Case Notes Report for BB (tab 44, p. 505); Report of Assistant Superintendent Stephen Tienstra dated 15 September 2012 (tab 50, p. 547); Statement of Assistant Superintendent Stephen Tienstra dated 12 November 2012 (tab 59, pp. 592-593 and p. 595)

a. BB was to remain subject to the RIT and receive focused case management;
b. BB was to remain one-out in a safe cell; and
c. BB was assessed as a "high" risk to himself, to others, and from others.[258]

RAIT Review on 23 August 2012

152. On 23 August 2012, BB was reviewed by an RAIT comprised of Assistant Superintendent Martin Cullen, psychologist Catherine Cheung and Clinical Nurse Consultant Marco Rec.[259]

153. Assistant Superintendent Cullen, Ms Cheung and CNC Rec signed an RAIT Management Plan dated 23 August 2012 which stated:
a. BB MNF had been terminated;
b. BB was to be placed in a normal cell;
c. BB was to be held in the Darcy Block until his mental health was reviewed; and
d. BB was a "low" risk of harm to himself and to others, however he was a "medium" risk of harm from others.[260]

154. Assistant Superintendent Cullen, Ms Cheung and CNC Rec signed an MNF dated 23 August 2012 which referred BB for routine case management and directed that he be placed in a normal cell .[261]

155. CNC Rec signed a HPNF dated 23 August 2012 which stated:
a. BB MNF had been terminated by the RIT;
b. BB was to be placed in a normal cell; and
c. BB was to be held in the Darcy Block until his mental health was reviewed.[262]

156. Also on 23 August 2012, Direction Number MRR1116609 was made, which placed BB on PRLA status.[263]

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[258]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [138] (tab 27, p. 204); Case Management File for BB (tab 35, p. 342)

Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [138] (tab 27, p. 204); Case Management File for BB (tab 35, p. 329); Case Notes Report for BB (tab 44, p. 505); Report of Catherine Cheung dated 20 September 2012 (tab 50, p. 537); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539); Statement of Catherine Cheung dated 21 November 2012 (tab 76, p. 845 and p. 847); Statement of Marco Rec dated 13 April 2016 (tab 87, p. 911)

[260]Case Management File of BB (tab 35, p. 329); Statement of Assistant Superintendent Martin Cullen dated 7 July 2016 (tab 58, p. 589-591); Statement of Marco Rec dated 13 April 2016 (tab 87, p. 911 and p. 917)

[261]Case Management File of BB (tab 35, p. 341); Statement of Marco Rec dated 13 April 2016 (tab 87, p. 911 and p. 916)

[262]Inmate Profile Document for BB (tab 33, p. 297); Case Management File of BB (tab 35, p. 338); Justice Health Records for BB (tab 98, p. 1843); Statement of Marco Rec dated 13 April 2016 (tab 87, p. 911 and p. 915)

Threat of self-harm on 24 August 2012

157. Around 5:20am on 24 August 2012, Senior Correctional Officers Harbir Singh and Paul Verbeek attended cell 85 in Pod 2 of Darcy Block.[264] BB was housed in this cell with another inmate.[265] BB had activated an alarm within his cell.[266] When the two Correctional Officers attended, BB threatened to harm himself.[267] BB was placed on an RIT and an MNF was completed.[268]

RAIT Review on 25 August 2012

158. On 25 August 2012, BB was reviewed by an RAIT comprised of Assistant Superintendent Carole Price, Registered Nurse Robin Osborne and Welfare Officer Sue Foster.[269] The RAIT determined BB was to remain on the MNF/RIT and be referred to a psychiatrist.[270]

159. Assistant Superintendent Price, RN Osborne and Ms Foster signed an RAIT Management Plan for BB dated 25 August 2012. The Management Plan describes BB as currently being a "high" risk to himself and from others, but a "low" risk to others.[271]

160. A Case Note signed by Ms Foster dated 25 August 2012 states "*At time of interview inmate was assessed as high risk of harm to self and others*".[272] On review of those notes however, Ms Foster made a correction, stating the Case Note entry should read, "At time of interview inmate was assessed as high risk of harm to self and from others".[273]

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[263]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [138] (tab 27, p. 204); Inmate Profile Document for BB (tab 33, p. 297); Care in Placement Report for BB (tab 36, p. 428)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [139] (tab 27, p. 204); Case Management File of BB (tab 35, pp. 334-337)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [139] (tab 27, p. 204); Case Management File of BB (tab 35, pp. 334-337)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [139] (tab 27, p. 204); Case Management File of BB (tab 35, pp. 334-337)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [139] (tab 27, p. 204).; Case Management File of BB (tab 35, pp. 334-337)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [139] (tab 27, p. 204); Case Management File of BB (tab 35, pp. 334-337)
Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [140] (tab 27, p. 204); Case Management File of BB (tab 35, p. 331); Case Notes Report for BB (tab 44, p. 507); Report of Assistant Superintendent Carole Price dated 24 December 2012 (tab 50, p. 549); Report of Sue Foster dated September 2012 (tab 50, p. 550); Statement of Robyn Osborne (tab 89, p. 921-922)
[270]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [140] (tab 27, p. 204); Case Management File of BB (tab 35, p. 331); Statement of Carol Price dated 26 April 2016 (tab 70, p. 644 and p. 646)
Case Management File of BB (tab 35, p. 331); Statement of Carol Price dated 26 April 2016 (tab 70, p. 643 and p. 645)
[272]Case Management File of BB (tab 35, pp. 332-333); Report of Sue Foster dated 21 March 2013 (tab 50, p. 551); Statement of Suzanne Foster dated 23 April 2016 (tab 72, p. 653 and p. 655)
[273] Report of Sue Forster dated 21 March 2013 (tab 50, p.551).

RAIT Review on 27 August 2012

161. On 27 August 2012, BB was reviewed by an RAIT comprised of Assistant Superintendent Stephen Tienstra, psychologist Catherine Cheung and Registered Nurse Astrid Munoz.[274]

162. An RAIT Management Plan signed by Assistant Superintendent Stephen Tienstra, Ms Cheung and RN Munoz dated 27 August 2012:
    a. Indicates BB mandatory status had been terminated;
    b. Directed BB was to receive routine case management instead of focused case management;
    c. Directed BB be placed in a two-out cell until 27 September 2012 when he would receive a mental health review;
    d. Noted BB "*fears for safety from others*";
    e. Noted BB had guaranteed his own safety if placed in Pod 2 of Darcy Block or Pod 16 of Hamden Block;
    f. Noted BB had a mental health problem, with a history of threat and ideations, and that he was "*paranoid of others*"; and
    g. Assessed that BB risk to himself, to others and from others was "low".[275]

163. An MNF signed by Assistant Superintendent Stephen Tienstra, Ms Cheung and RN Munoz dated 27 August 2012:
    a. Referred BB for routine case management;
    b. Noted BB guaranteed his own safety if placed in Pod 2 of Darcy Block or Pod 16 of Hamden Block;
    c. Directed BB be placed in a two-out cell until 27 September 2012 when he would receive a mental health review; and
    d. Stated BB was "*paranoid of others*".[276]

164. A HPNF signed by RN Munoz and Assistant Superintendent Tienstra dated 27 August 2012 states:
    a. BB has a history of "*mental issues*";
    b. BB has "*paranoid ideations*";
    c. BB RIT had been terminated;
    d. BB is "*Cleared to Hamden Pod 16*"; and

[274]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [142] (tab 27, p. 205); Case Management File for BB (tab 35, p. 324-328); Case Notes Report for BB (tab 44, p. 507); Report of Catherine Cheung dated 20 September 2012 (tab 50, pp. 537-538); Report of Assistant Superintendent Stephen Tienstra dated 15 September 2012 (tab 50, p. 547); Statement of Assistant Superintendent Stephen Tienstra dated 12 November 2012 (tab 59, pp. 592-593 and p. 595); Statement of Catherine Cheung dated 21 November 2012 (tab 76, pp. 845-846 and p. 849)
[275]Case Management File of BB (tab 35, p. 326); Statement of Astrid Munoz dated 22 April 2016 (tab 91, p. 932)
[276]Case Management File of BB (tab 35, p. 325)

e. BB is to be placed in a two-out cell until 27 September 2012.[277]

165. As a result of the RAIT review on 27 August 2012, BB was placed on a "Green Card".[278] An inmate who is on a Green Card is required to be housed with another inmate ("two-out" in a cell).[279]

Review by Dr Gordon Elliott on 27 August 2012

166. On 27 August 2012, BB was reviewed by Consultant Psychiatrist Dr Gordon Elliott. Dr Elliott did not have access to all of the Justice Health record and had no access to the CSNSW record.[280] Dr Elliott noted BB had already retracted his threat of self-harm with a promised move to another pod. Dr Elliott did not consider BB was suicidal, and did not consider BB required containment in a safe cell. Dr Elliott agreed that BB should be transferred back to the Hamden Block.

Request to remain in the Darcy Block from 28-30 August 2012

167. On 28 August 2012, BB approached Assistant Superintendent Martin Cullen.[281] BB asked to remain in the Darcy Block until he was cleared to move to Pod 16 of Hamden Block.[282] Assistant Superintendent Cullen placed an alert on the Offender Information Management System (**"OIMS"**) for BB to remain in the Darcy Block until 30 August 2012.[283]

Placement of BB in Hamden Block on 30 August 2012

168. On 30 August 2012, BB approached Assistant Superintendent Martin Cullen. BB asked to move to Pod 16 of Hamden Block as soon as possible.[284]

169. Assistant Superintendent Martin Cullen spoke to Senior Correctional Officer Evan Panelo regarding BB request to transfer to Pod 16 of Hamden Block.[285]

170. At approximately 12:40pm on 30 August 2012, BB was transferred from the Darcy Block to Pod 16 of the Hamden Block.[286] BB was placed in a holding cage.[287]

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[277]Case Management File of BB (tab 35, p. 324); Justice Health Records for BB (tab 98, p. 1842); Statement of Astrid Munoz dated 22 April 2016 (tab 91, p. 932)
[278]Statement of Astrid Munoz dated 22 April 2016 at [14]-[15] (tab 91, p. 933)
[279]Statement of Astrid Munoz dated 22 April 2016 at [14]-[15] (tab 91, p. 933)
[280] Supplementary statement of Dr Gordon Elliott dated 17 August 2018 at [10]-[16] (tab88A, p.920B-920C).
[281]Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)
[282]Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)
[283]Inmate Profile Document for BB (tab 33, p. 297)
[284]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [144] (tab 27, p. 205); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)
[285]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [144] (tab 27, p. 205); Report of Assistant Superintendent Martin Cullen dated 6 September 2012 (tab 50, p. 539)
[286]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [145] (tab 27, p. 206); Report of Senior Correctional Officer Evan Panelo dated 7 September 2012 (tab 38, p. 435); Statement of Senior Correctional Officer Evan Panelo dated 30 October 2012 (tab 62, pp. 601-602)

171. Senior Correctional Officer Evan Panelo:
    a. Reviewed Mr BB file;
    b. Interviewed Mr BB
    c. Reviewed information regarding other inmates housed in Pod 16 of Hamden Block; and
    d. Decided to place Mr BB in Cell 407 with DJ [288]

172. Senior Correctional Officer Panelo was assisted at this time by First Class Correctional Officer Jeremy Leighton-Jones.[289]

173. Around 2:00pm on 30 August 2012, Mr BB was transferred to Cell 407 and housed with DJ [290]

Events of 31 August 2012 to 1 September 2012

Review of DJ by psychologist Alita Caon (2:15pm-3:00pm)

174. Between 2:15pm and 3:00pm on 31 August 2012, DJ was reviewed by psychologist Alita Caon.[291]

175. Following this review, Ms Caon noted that DJ was housed with Mr BB [292] Ms Caon then informed First Class Correctional Officer Jason Spooner that DJ was housed with Mr BB and noted Mr BB had not been charged with a sex offence.[293]

176. Following Ms Caon's contact with First Class Correctional Officer Spooner, Senior Correctional Officer Peter Wilson and First Class Correctional Officer Spooner reviewed

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[287]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [145] (tab 27, p. 206); Report of Senior Correctional Officer Evan Panelo dated 7 September 2012 (tab 38, p. 435); Statement of Senior Correctional Officer Evan Panelo dated 30 October 2012 (tab 62, pp. 601-602); Statement of Jeremy Leighton-Jones dated 25 October 2012 (tab 67, pp. 626-627)

[288]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [145] (tab 27, pp. 206-208); Report of Senior Correctional Officer Evan Panelo dated 7 September 2012 (tab 38, pp. 435-436); Statement of Senior Correctional Officer Evan Panelo dated 30 October 2012 (tab 62, pp. 601-603)

[289]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [149] (tab 27, p. 208); Report of Senior Correctional Officer Evan Panelo dated 7 September 2012 (tab 38, p. 435); Report of First Class Correctional Officer Jeremy Leighton-Jones dated 6 September 2012 (tab 38, p. 438); Statement of Senior Correctional Officer Evan Panelo dated 30 October 2012 (tab 62, pp. 601-603); Statement of Jeremy Leighton-Jones dated 25 October 2012 (tab 67, pp. 626-627)

[290]*R v* BB [2014] NSWSC 1274 at [17] (tab 5, p. 32); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [9] (tab 27, p. 180); Prisoner Cell Register for Cell 407 (tab 32, p. 292); Housing Location History of Brian BB (tab 34, p. 303)

[291]Report of Alita Caon dated 3 September 2012 (tab 42, p. 479); Case Note Reports for DJ (tab 43, p. 492); Statement of Alita Caon dated 24 October 2012 (tab 77, p. 851 (at [7]) and p. 854); Transcript of evidence given by Alita Caon on 9 September 2014 (tab 78, p. 857)

[292]Report of Alita Caon dated 3 September 2012 (tab 42, pp. 479-480); Report of Alita Caon dated 5 September 2012 (tab 42, pp. 483); Statement of Alita Caon dated 24 October 2012 (tab 77, pp. 854-856)

[293]Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 39, p. 440); Report of First Class Correctional Officer Jason Spooner dated 20 September 2012 (tab 38, p. 445); Report of Alita Caon dated 3 September 2012 (tab 42, pp. 479-480); Report of Alita Caon dated 5 September 2012 (tab 42, pp. 483); Statement of First Class Correctional Officer Jason Spooner dated 25 October 2012 (tab 68, p. 632); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 638); Statement of Alita Caon dated 24 October 2012 (tab 77, pp. 854-856)

documents relating to BB placement in a cell with DJ and no change was made to the cell placements.[294]

Head-check and lock-in (3:00pm-3:30pm)

177. Between 3:00pm and 3:20pm on 31 August 2012, Senior Correctional Officer Peter Wilson and First Class Correctional Officer Jason Spooner conducted a "head-check".[295]

178. Neither DJ nor BB expressed any concerns to Senior Correctional Officer Wilson or First Class Correctional Officer Spooner at that time.[296]

179. Cell doors were locked for the night at 3:30pm.[297]

Medication round (7:00pm)

180. Around 7:00pm on 31 August 2012, Registered Nurse Lauren Lennon attended Cell 407 to dispense BB anti-psychotic medication.[298]

181. BB refused the medication.[299]

Night-time disturbances and the death of DJ (12:30am)

182. During the night of 31 August to 1 September 2012, inmates heard disturbances and cries for help coming from the direction of Cell 407.[300]

183. Around 12:30am on 1 September 2012, inmate JD who occupied Cell 411, heard someone crying "help me" about four or five times.[301] JD heard these words coming from the direction of Cell 407, and believed they were spoken by DJ[302]

[294]Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 39, p. 440); Report of First Class Correctional Officer Jason Spooner dated 20 September 2012 (tab 38, p. 445); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 638)
[295]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [150] (tab 27, p. 210); Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 441); Report of First Class Correctional Officer Jason Spooner dated 20 September 2012 (tab 38, p. 445); Inmate Accommodation Journal (tab 41, pp. 463-464); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 639); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 813)
[296]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [150] (tab 27, p. 210); Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 441); Report of First Class Correctional Officer Jason Spooner dated 20 September 2012 (tab 38, p. 445); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 639)
[297]Report of Senior Correctional Officer Peter Wilson dated 10 September 2012 (tab 38, p. 441); Inmate Accommodation Journal (tab 41, pp. 463-464); Statement of Senior Correctional Officer Peter Wilson dated 16 October 2012 (tab 68, p. 639); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 813)
[298]*R v* BB [2014] NSWSC 1274 at [34] (tab 5, p. 37) and at [85] (tab 5, p. 51); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [20] (tab 27, p. 182); Statement of Lauren Lennon dated 19 March 2013 (tab 80, p. 874-75); Transcript of evidence given by Lauren Lennon on 8 September 2014 (tab 81, pp. 879-880)
[299]*R v* BB [2014] NSWSC 1274 at [34] (tab 5, p. 37); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [22] (tab 27, p. 182); Statement of Lauren Lennon dated 19 March 2013 (tab 80, p. 874-75); Transcript of evidence given by Lauren Lennon on 8 September 2014 (tab 81, p. 883)
[300]*R v* BB [2014] NSWSC 1274 at [38]-[60] (tab 5, pp. 38-44) and [135]-[143] (tab 5, pp. 65-67)
[301]*R v* BB [2014] NSWSC 1274 at [40] (tab 5, pp. 38-39) and [160] (tab 5, pp. 72-73); Statement of JD dated 5 September 2012 at [5] (tab 18, p. 148)
[302]*R v* BB [2014] NSWSC 1274 at [40] (tab 5, pp. 38-39) and [160] (pp. 72-73)

"Knock-up" and response (2:15am-2:45am)

184. Around 2:15am, inmate TM in Cell 413 heard somebody call out "DJ followed by "*oh no, what have you done?*".[303] TM then heard somebody say "*He's hung himself. I can't get him down. He's too heavy*".[304] Similar statements were heard around this time by TM cellmate PT[305] and by inmate SM in Cell 412.[306]

185. Around 2:20am-2:25am on 1 September 2012, Corrective Services Officers received an emergency call (referred to as a "knock-up" call) from Cell 407.[307] The call was made by BB and received by Corrective Services Officer Jason Baptista.[308]

186. Corrective Services Officers Jason Baptista, Matthew Loftus, Tulo McDougal, Jason Trench, Chris Kaisa and Aukusitino Aukusitino made their way to Cell 407.[309] They arrived at 2:29am.[310] They found DJ had no pulse but was still warm.[311]

187. Corrective Services Officer Trench used a "911 tool" to remove white cloth material which was tied around DJ neck.[312]

188. Nurses Jiliane Sergeant and Natalie Apap also attended Cell 407 attempted cardio-pulmonary resuscitation (**"CPR"**) of DJ[313]

189. Around 2:40am the nurses decided to cease CPR after determining any further attempt at resuscitation would be futile.[314]

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[303] *R v* BB [2014] NSWSC 1274 at [43] (tab 5, pp. 39-40); Statement of TM dated 5 September 2012 at [6] (tab 17, p. 147)
[304] *R v* BB [2014] NSWSC 1274 at [43] (tab 5, pp. 39-40); Statement of TM dated 5 September 2012 at [6] (tab 17, p. 147)
[305] *R v* BB [2014] NSWSC 1274 at [43]-[44] (tab 5, pp. 39-40); Statement of PT dated 5 September 2012 at [15]-[17] (tab 25, p. 173)
[306] *R v* BB [2014] NSWSC 1274 at [46]-[47] (tab 5, pp. 40-41); Statement of SM dated 5 September 2012 at [15] (tab 21, p. 158)
[307] *R v* BB [2014] NSWSC 1274 at [61] (tab 5, p. 44); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [23] (tab 27, p. 183); Inmate Accommodation Journal (tab 41, p. 466); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 692, p. 694 and p. 806)
[308] *R v* BB [2014] NSWSC 1274 at [61] (tab 5, p. 44); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, pp. 674-675)
[309] *R v* BB [2014] NSWSC 1274 at [62] (tab 5, p. 44); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [24] (tab 27, p. 183); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, pp. 670-673 and pp. 675-676)
[310] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [25] (tab 27, p. 183)
[311] *R v* BB [2014] NSWSC 1274 at [64] (tab 5, p. 45); Statement of Natalie Apap dated 10 October 2012 at [12] (tab 83, p. 894); Transcript of evidence given by Natalie Apap on 8 September 2014 (tab 84, pp. 899-900)
[312] *R v* BB [2014] NSWSC 1274 at [65] (tab 5, p. 45); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [27] (tab 27, p. 184); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 670-671, p. 692 and p. 694)
[313] Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, pp. 670-671, p. 675, p. 678, p. 683); Statement of Jilane Sarjeant dated 16 October 2012 (tab 82, p. 890); Statement of Natalie Apap dated 10 October 2012 (tab 83, p. 895 (at [14) and p. 896); Transcript of evidence given by Natalie Apap on 8 September 2014 (tab 84, p. 899)
[314] *R v* BB [2014] NSWSC 1274 at [66] (tab 5, p. 45); Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [28] (tab 27, p. 184); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 678, p. 683 and pp. 692-694); Statement of Jilane Sarjeant dated 16 October 2012 (tab 82, p. 890); Statement of Natalie Apap dated 10 October 2012 (tab 83, p. 895 (at [14) and p. 896); Transcript of evidence given by Natalie Apap on 8 September 2014 (tab 84, p. 899)

Attendance by Ambulance and Police officers (2:45am onwards)

190. Around 2:45am on 1 September 2012, Ambulance officers attended the scene and confirmed DJ was deceased.[315]

191. Police officers from Flemington Local Area Command attended from around 3:15am.[316]

192. Detectives from the Corrective Services Investigation Unit attended from around 4:25am.[317]

193. A Senior Constable from the Forensic Services Group attended from around 4:40am.[318]

194. Detectives from the Homicide Squad attended from around 7:25am.[319]

195. The last police officers to leave the scene departed at 9:40am.[320]

Arrest of BB (8:40am onwards)

196. Around 8:40am on 1 September 2012, BB was conveyed from the MRRC to Auburn Police Station.[321]

197. BB arrived at Auburn Police Station around 9:30am.[322] BB was informed that he was under arrest for the murder of DJ [323]

Post-mortem examination (6:10am and 1:00pm onwards)

198. Around 6:10am on 1 September 2012, Forensic Pathologist Dr Istvan Szentmariay attended the scene.[324]

199. DJ body was removed by Government Contractors around 8:55am.[325]

200. Around 1:00pm on 1 September 2012, Dr Szentmariay performed a post-mortem examination on DJ body.[326] Dr Szentmariay found the cause of DJ death

[315]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [33] (tab 27, p. 185); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 678 and p. 693); Statement of Jilane Sarjeant dated 16 October 2012 (tab 82, p. 890); Statement of Natalie Apap dated 10 October 2012 (tab 83, p. 895 (at [16) and p. 896); Transcript of evidence given by Natalie Apap on 8 September 2014 (tab 84, p. 899)
[316]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [33] (tab 27, p. 185); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 678)
[317]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [35] (tab 27, p. 185)
[318]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [35] (tab 27, p. 185)
[319]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [35] (tab 27, p. 185)
[320]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [40] (tab 27, p. 186)
[321]Fact Sheet prepared by Detective Senior Constable Stephen King dated 7 May 2013 (tab 7, p. 86)
[322]Fact Sheet prepared by Detective Senior Constable Stephen King dated 7 May 2013 (tab 7, p. 87); NSW Police Force Custody Management Record for BB (tab 6, p. 89)
[323]Fact Sheet prepared by Detective Senior Constable Stephen King dated 7 May 2013 (tab 7, p. 87)
[324] Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 679 and p. 685)
[325]Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [39] (tab 27, p. 185); Statement of Mustafa Alkhatib dated 6 July 2016 (tab 74, p. 680)
[326]Autopsy Report (tab 2, p. 7); *R v* BB [2014] NSWSC 1274 at [7] and [69]-[82] (tab 5, p. 29 and pp. 46-50)

was neck compression.[327] Dr Szentmariay identified other injuries of recent origin which were the result of the application of blunt force.[328]

Criminal proceedings against BB

201. On 7 May 2013, BB was charged with the murder of DJ [329]

202. BB was tried before a judge alone in the NSW Supreme Court in September 2014.[330] The evidence at trial included expert psychiatric evidence that BB suffers from a chronic schizophrenic illness and that he was psychotic throughout the majority of 2012 up to and including the time of his arrest in June 2012, especially given his history of treatment resistance. He remained psychotic at the time of DJ death.

203. The expert evidence was that BB apparently heard voices he took to be from aliens, believed that he would be killed, and was suffering from self-referential thinking, and that BB also believed DJ wanted to kill him, despite never having met him before.

204. The trial judge found that:
    a. BB strangled DJ to death using a power cord from a television in Cell 407; [331]
    b. This was a deliberate act by BB [332]
    c. After BB strangled DJ BB took steps to try to create the impression DJ had taken his own life;[333] and
    d. At the time BB strangled DJ BB "*held a belief that everyone, including the deceased, was trying to kill him*".[334]

205. BB was found not guilty on the grounds of mental illness.[335]

Scope for recommendations arising from the evidence

206. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death.

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[327] Autopsy Report (tab 2, pp. 8-9); *R v* BB [2014] NSWSC 1274 at [7] and [70]-[72] (tab 5, p. 29 and p. 47)
[328] Autopsy Report (tab 2, p. 9); *R v* BB [2014] NSWSC 1274 at [7] and [80]-[82] (tab 5, p. 29 and pp. 49-50)
[329] Court Attendance Notice (tab 6, p. 81)
[330] *R v* BB [2014] NSWSC 1274 (tab 5, p. 26)
[331] *R v* BB [2014] NSWSC 1274 at [164] (tab 5, p. 74)
[332] *R v* BB [2014] NSWSC 1274 at [164] (tab 5, p. 74)
[333] *R v* BB [2014] NSWSC 1274 at [165] (tab 5, p. 74)
[334] *R v* BB [2014] NSWSC 1274 at [166] (tab 5, p. 74)
[335] *R v* BB [2014] NSWSC 1274 at [180]-[182] (tab 5, p. 79)

207. The evidence arising from this inquest, involving two deaths, draws into focus the difficulties medical professionals face in managing acutely mentally ill patients within the correctional environment. Coroners have previously examined some of these issues in relation to the particular needs of inmates at risk of suicide and serious self-harm. This inquest has focussed on the risk to others that some acutely ill inmates may pose.

208. In hindsight, there were clearly shortcomings in the medical care delivered to both MA [redacted] and BB These involved deficiencies in the level of dedicated psychiatric care they could receive within the prison environment. BB for example was both under-medicated and his non-compliance was not adequately monitored or communicated. Both men may have benefitted from closer supervision had a psychiatrist been available for more frequent review. However, the focus during these proceedings has not been to criticise or single out individual decision makers or practitioners. It is recognised that the conditions under which all staff work at the MRRC are extremely stressful and at times dangerous. Staff are under-resourced and need to make clinical decisions with resourcing practicalities in mind. It is accepted that the options they have available for patients are often very limited. The only purpose of reviewing individual decisions in these proceedings is to better understand the conditions and stressors operating at the time with a view to discovering if systems can be enhanced to improve the care provided.

209. Dr Spencer, forensic psychiatrist and clinical director of custodial mental health employed by Justice Health, explained the difficult decisions medical staff face on a daily basis when discussing her care of BB

> *"I could have made a different decision on the day I saw him and I feel for colleagues who made the decisions they made but ultimately I don't think there is really an easy solution or an easy answer as to how we could do things better. Safe cells are awful places as well and being in custody is horrible. Being in Long Bay Hospital is pretty horrible and the screening unit is pretty horrible but it's the best we've got. Unless there is a massive overhaul people are going to keep dying either at the hands of their cellmate or because they take their own life. There is no easy answer."*[336]

210. It may be that we need to work towards "a massive overhaul" in the long term. In the meantime it is helpful to examine the specific issues identified in the evidence where the need for immediate change is indicated.

[336] TS 28/8/18 p 102.23 onwards

The need to stop managing inmates who have an acute mental illness in the general prison population

211. The background risk factor, which cannot be ignored, is that we continue to house acutely mentally ill prisoners within the general prison population. While it may be possible to house those in remission or with a chronic but not acute mental illness appropriately in the general prison population, it is increasingly clear that the management of all acutely mentally ill prisoners outside a custodial setting would constitute best practice.

212. There is a related factor relevant to both deaths. The circumstances under which we conduct inmate health screenings may mean that we frequently fail to identify acute mental illness or underestimate its severity. Given the known lack of resources within the system, only the most obviously unwell prisoners will be escalated for immediate care.

213. The court was assisted by the evidence of Dr Westmore on this issue. Dr Westmore is an eminent forensic psychiatrist who has worked both in the community and in forensic settings both in Australia and overseas.[337] He recommended that that whenever a prisoner is identified as being mentally ill (acute) they should never be managed within the general prison population. He stated "mentally ill prisoners should be transferred to the dedicated forensic hospital facility managed by the Health Department or, as an alternative, they should be managed within a dedicated medical psychiatric section of the general prison system".[338]

214. Dr Westmore told the court that mentally ill people are over-represented in the prison population when compared to the general population. When managed in prison they are particularly vulnerable. Dr Westmore explained that when they are not managed primarily by health staff their needs may be misunderstood and unmet. It follows that their recovery is less than optimal. He explained that medication is a good example. In the general prison population the taking of medication may not be a priority. Refusal or non-compliance may take time to be reported to a relevant doctor, its significance not properly understood. Perhaps another example raised in the evidence was the routine placement of mentally ill patients with inmates who may have some other need for protection, such as sex offenders. The groups have no natural alliance, except that both may be vulnerable in custody. With hindsight it is clear that BB should not have been housed with somebody charged with a sexual offence, it was a situation that properly managed from a medical perspective should not have occurred. However, within the contingencies of a correctional environment it is not unusual.

[337] Curriculum vitae of Dr Bruce Westmore (tab 39A) and also TS 28/2/19, p 60.25 onwards
[338] Report of Dr Bruce Westmore dated 18 June 2018 at [6] (tab 107, p. 3632); see also TS 28/2/19 p60.45

215. Dr Westmore described the process of moving acutely unwell prisoners out of correctional settings and into secure hospital care, run by medical staff as the best way forward. He spoke enthusiastically of his experience in the UK, "they've been doing it all over the rest of the world for years." He stated that health staff have demonstrated over many years that proper security can be provided. He told the court "I guess, this is the future and, if we haven't got it yet, we've got to keep moving towards it. We've got to keep moving patients out of prisons and treat them."[339]

216. The court heard that currently the Long Bay Hospital can treat only a tiny proportion of inmates requiring mental health services. Dr Spencer stated, in her evidence, that the capacity of Long Bay Hospital is 44 beds[340]. The Mental Health Screening Unit (**"MHSU"**)[341] always has a long waiting list, so eligible patients are at times not even put forward for admission. Dr Spencer stated, in her evidence, that as at the date of her evidence there was a waiting list across the state of approximately 30 to 40 prisoners[342]. There is considerable pressure in Darcy and Hamden, where there may be greater access to mental health staff, but where conditions remain unconducive to appropriate medical care.

217. Dr Spencer spoke eloquently of the difficulties of working within the system. When asked if more beds were needed in units such as the MHSU and Long Bay Hospital she agreed, adding that *"I think it would be even more ideal if we had more beds available in the community, so no patients were ever treated in custody, but as it currently stands all our prisons are full of mentally ill patients and we just don't have the resources to be able to treat them, beds or psychiatrists or mental health nurses or psychologists, our hands are tied."*[343]

218. The court accepts that to move all acutely mentally ill inmates into hospital care is currently impossible in practice in NSW. The facilities do not exist, nor are there enough appropriate medical staff on hand. Nevertheless, I heard considerable evidence about new custodial building projects currently underway at the MRRC and elsewhere. Long term plans and budgetary allocations are being made. Unfortunately I heard little about projects to build major new health facilities to treat acutely mentally unwell prisoners, despite the demonstrated need.

219. I am aware that following the *Inquest into the death of Fenika Junior Tautuliu Fenika (Junior Fenika)*, Acting State Coroner O'Sullivan made a recommendation to the Minister for Corrections, the Minister for Health and the Commissioner of Corrective Services that

[339] TS 28/2/19 p72.40
[340] TS 28/8/18 p 109.5
[341] Dr Spencer described the MHSU as "our quasi voluntary in-patient unit" TS 28/8/18 p78.20
[342] TS 28/8/18 p 108.20
[343] TS 28/8/18 p100.9 onwards

called for a comprehensive review to determine whether the number of beds available for mentally ill patients within the NSW correctional system is currently adequate. That important review is apparently underway and is certainly supported. However at the same time we need to be researching what is possible in the longer term. It may be that it is necessary to reframe and refocus the way we think of mental health treatment in a custodial setting in a much more profound way. Further research is needed. With some regret, I accept that it is well beyond the scope of the evidence before me to recommend an immediate transfer of all acutely mentally ill patients out of the custodial system for treatment, in line with Dr Westmore's suggestion[344]. Nevertheless, there is a strong need for research to ground future planning. It is appropriate to make a recommendation to examine the feasibility and clinical benefits of making significant long term change in this area.

The need to improve information sharing between Justice Health and CSNSW – the HPNF and the RIT/RAIT process

220. There are very sound reasons for Justice Health to have strong policies around the privacy of health information. Justice Health submitted, and I accept, that effective treatment is supported by providing a forum where open and free exchange of health information between practitioner and patient is protected. It is necessary for the inmate patient to have confidence in the privacy of their exchanges to develop a sound rapport with relevant health professionals.

221. Justice Health also accept that the right to confidentiality is not absolute, and guidelines already make it clear that information may be disclosed if the relevant Justice Health practitioner forms the view that a custodial patient's mental or physical condition constitutes a risk to the life, health or welfare of another person.[345]

222. I accept that there may be a delicate balance between a patient's right to privacy and the need to disclose sufficient information if a risk of harm is identified. The court was concerned with learning how information sharing between CSNSW and Justice Health currently works and if there are ways of improving that exchange without damaging the therapeutic relationship. If one accepts that large numbers of mentally ill prisoners will continue to be managed in the mainstream prison population, there is a need to have confidence in the methods in place.

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[344] See the Report of Dr Westmore, 18 June 2018 [6] He writes "I would be recommending that whenever a prisoner is identified as being mentally ill (acute) they should never be managed within the general prison population. Mentally ill prisoners should be transferred to the dedicated forensic hospital's facility managed by the Health Department or as an alternative they should be managed within a dedicated medical/psychiatric section within the general prison system. I appreciate that arguments will be raised in relation to the provision of staff and facilities for this particular recommendation but it would be useful if this recommendation could eventually lead to a best practice model and possibly something that Corrective Services and/or Health could look at in the future." Dr Westmore was cross-examined on his recommendation at TS 28/2/19 p 72 and elsewhere

[345] Statement of Trevor Perry, 15 March 2018, Annexure F at p 9

223. Currently, and at the time of the deaths under investigation, the main conduit of information between Justice Health and CSNSW is the Health Problem Notification Form ("**HPNF"**). The policy governing HPNFs, which has remained relatively static between 2010 and 2019, presently states:

> *"The [HPNF] communicates Justice Health & Forensic Mental Health Network (JH&FMHN) advice and recommendations regarding an adult patient's clinical status to [CSNSW]. This information may concern cell placement recommendation, or possible signs of conditions and illness, such as substance withdrawal, mental health, or patients on blood thinning agents… JH&FMHN clinicians have a duty of care and a statutory duty to advise CSNSW custodial officers of actual or potential "at-risk" health problems. The HPNF is specifically for this purpose. … Relevant signs of symptoms must be expressed in 'lay language' for CSNSW custodial officers."*[346]

224. Where an inmate is in a state of crisis there may be a number of HPNFs created in a short time frame, as the policy for HPNFs requires a new HPNF to be created whenever a patient's clinical presentation changes.[347] For example a Mandatory Notification Form ("**MNF"**) is required when CSNSW suspect an inmate to be at risk of suicide or self-harm and is used to notify the relevant officer in charge of an inmate of that risk. A new HPNF is generated as a result of an MNF.

225. Once a risk of suicide or self-harm is identified, the inmate will be placed on a RIT (Risk Intervention Team). The Court heard from a number of witnesses that a RIT is a multidisciplinary team with staff from CSNSW and Justice Health responsible for assessing inmates at risk of suicide or self-harm.[348] For historical reasons, RITs at the MRRC are referred to as Risk Assessment and Intervention Teams or "**RAIT**s". A RAIT generally consists of the CSNSW custodial RIT co-ordinator – in this inquest it appears that this role was always performed by an Assistant Superintendent – a CSNSW psychologist or member of Offender Services and Programs and a Justice Health staff member, which at the MRRC is intended to be always a registered mental health nurse. These arrangements appear to have remained consistent from 2010 until today.

226. The RAIT meet and discuss the risk a particular inmate presents and formulate an agreed risk management plan for the inmate. The plan must have three components:

    a. consideration of accommodation options;

[346] Statement of Trevor Perry, 10 December 2018, annexure E, page 2
[347] Statement of Trevor Perry, 10 December 2018, annexure E, page 2
[348] Statement of Terry Murrell, 23 February 2018, annexures 6 (pp 8-20), 7 (pp 15-24) and 8 (pp 18-29) (VA2 T6 pp 82-94, 112-121 and 139-150); note that the policies have remained relevantly static between 2010 and today for the purposes of these inquests

b. observations/monitoring; and

c. access to amenities.

227. The RAIT will also identify specialist or other appropriate referrals as necessary. A new HPNF is generated following the RAIT meeting.

228. Assistant Superintendent Cullen gave evidence that at the end of a RAIT interview the HPNF issued would be placed in the Justice Health file and a copy on the CSNSW case file and a copy would also go to the officer in the relevant wing so that he knows what type of regime was going to be put in place for the inmate.[349] Assistant Superintendent Cullen gave evidence that the form is used to inform officers who are running the relevant pod of what accommodation was appropriate and what other measures need to be taken to ensure the safety of the inmate. He gave evidence that although the information on the HPNF was a recommendation it would be followed in 99% of the cases he sees.[350]

229. It is intended that the HPNF will provide information about chronic mental health problems that may be classed as "at-risk" health conditions. It is noted, in this context, that the *Crimes (Administration of Sentences) Regulation 2014* requires a Justice Health officer to disclose certain matters to CSNSW officer as soon as practicable after the Justice Health officer forms the opinion that the mental condition of an inmate constitutes a risk to the life, health or welfare of any other person.[351] Evidence provided by Justice Health states that the HPNF policy is relevant to this statutory requirement.[352]

230. Close examination of the evidence tendered in relation to the death of DJ revealed at the time of BB cell placement with DJ Justice Health held significant information on file which indicated that BB was unwell and likely to be a risk of harm to others. This information included material written by Dr Elliott as early as 2008. Dr Elliott agreed in evidence that the features of BB illness had been consistent between 2008 and 2012. This is not to suggest that all the information was readily available to any individual, but that it existed in Justice Health records.

231. By the time of DJ death, BB had 12 HPNFs created between 6 June 2012 and 27 August 2012. There was no continuing reference to BB mental health condition and no reference to signs and symptoms that indicated that he was unwell and, as a result, a risk of harm to others, apart from the final HPNF prepared before DJ

[349] TS 29/8/18 p 135.22-29
[350] TS 29/8/18 p 135.43
[351] *Crimes (Administration of Sentences) Regulation 2014* cl 285(a)
[352] Statement of Trevor Perry, 15 March 2018, annexure F p 9

death.[353] It is noted that there was an active alert on BB Inmate Profile Document dated 3/9/2012 for serious mental illness - medication – DCS[354] (dated 24/2/2009) but without further information this alert was of little apparent utility.[355] It is also noted that in BB MHSU discharge management plan, which appeared in BB CSNSW file, it is stated that BB had a history of "paranoia and may be a risk to others".[356] However, nowhere was it said that *when* BB was exhibiting signs of paranoia he may be a risk of harm to others, being key in the context of the features of BB illness.

232. There are two aspects of the events leading up to DJ death that demonstrate the importance of information about the features of BB illness being readily available to CSNSW officers. Firstly, at the RAIT meeting on 23 August 2012, BB was unable to be persuaded that he would be safe where he was housed at that time.[357] Assistant Superintendent Cullen accepted that this presentation to the RAIT would have demonstrated that BB was extremely unwell had relevant background information regarding the symptoms of BB mental illness been available, but did not accept that it would have made a difference to the RAIT decision.[358] Ms Cheung gave evidence that it was "very likely" that the RAIT decision would have been affected by background information about BB illness, given his presentation.[359]

233. Secondly, the decision to place BB in a cell with DJ is likely to have been affected by the availability of more information about BB history. Mr Wilson gave evidence that had he and other officers involved in the decision about where to place BB had access to information about BB mental health, they may well have changed their decision as to whether he was suitable to be housed with a sex offender[360] – DJ had been charged with sexual offences. In particular, Mr Wilson gave evidence that information about BB non-compliance with medication would have been significant to him, but only if he had also had information about BB pattern of functioning relatively normally while on his medication and then slowly deteriorating into a world of paranoia and delusion when he stopped his medication.[361] While Mr Wilson said in evidence that he understood the need for patient privacy, he also considered that it was important that CSNSW officers be provided with

[353] See page 103 of annexures to attachment 1 (Exhibit 5)
[354] V1 T33 p 296
[355] TS 29/8/18 p 141-142
[356] See page 81 of annexures to attachment 1 (Exhibit 5)
[357] Statement of Assistant Superintendent Martin Cullen, 14 November 2012, annexure report of Martin Cullen dated 6 September 2012 (V2 T56 p 584)
[358] TS 29/8/18 pp 146-7
[359] TS 29/8/18 p 188.19
[360] TS 30/8/18 p 289.6ff
[361] TS 30/8/18 p 289.20

information about a person's health needs that, in the opinion of those treating them, might cause that person to be a risk of harm to others.[362] He did not understand – perhaps incorrectly – that the HPNF was the form by which that information could have been provided to him but he specifically identified information about non-compliance with medication as being something that officers would like access to.[363]

234. Consistent with Mr Wilson's evidence, the CSNSW internal report into DJ death commented that CSNSW officers are provided with little information as to an inmate's medical history or current conditions, noting that once an inmate is cleared for placement by way of HPNF, officers have to house and manage them accordingly.[364]

235. Mr Rec gave evidence that there was no reason to put information about the nature of BB illness or lack of treatment, such as symptoms, onto an HPNF.[365] However, Mr Rec subsequently gave evidence that information about the features of BB illness, such as that it was characterised by paranoia of harm from others, is information that should be on an HPNF.[366]

236. Dr Elliott gave evidence that information of that kind was information that he would expect to see on an HPNF, albeit very succinctly stated. He also gave evidence that, to the extent that BB illness indicated that it was contrary that he be put in a cell with a sex offender, that information would be provided to CSNSW through the HPNF.[367] He gave evidence that the HPNF would carry forward because it is retained at the front of CSNSW case files, but acknowledged that the information would not remain on each subsequent HPNF, as they change.[368] Dr Elliott gave evidence of his opinion that information - such as information about the features of BB illness - that are consistent over time as a concern should carry over from HPNF to HPNF.[369]

237. Dr Westmore gave evidence that he considered that it was important that Justice Health provide CSNSW with information about whether or not an inmate is taking their anti-psychotic medication in order to assist in determining cell placement.[370] Dr Westmore also gave evidence that BB history meant he should not have been housed with a sex offender.[371]

238. The evidence set out above suggests that a change to policies and practices governing information sharing between CSNSW and Justice Health may be appropriate. It appears

[362] TS 30/8/18 p 290.1
[363] TS 30/8/18 p 290.6ff
[364] Report of Grant Simpson, CSNSW Investigations, dated 17 June 2014 at [2] (tab 27, p. 219)
[365] TS 27/2/19 p 43.8
[366] TS 28/2/19 p 60.30ff
[367] TS 28/2/19 p 27.28
[368] TS 28/8/18 p 95.20
[369] TS 28/2/19 p 24.15-49
[370] TS 28/2/19 p 70.27-39
[371] Report of Dr Bruce Westmore, 18 June 2018, p 2 (V6 T107)

from the evidence that it may be that the HPNF is the correct mechanism by which such information can be provided to CSNSW, but that that it was not being used in that way in BB case.

239. A change to the current HPNF policy may be required to make this function of the HPNF clearer than it currently is, and some mechanism may need to be added to ensure that signs and symptoms of chronic, relevant health problems are carried over from HPNF to HPNF. If that is not possible, it may be necessary to create an alert system that includes relevant health information, such as that outlined above.

240. Given time and resourcing constraints in the custodial environment, these changes are likely to be more achievable than requiring the preparation of a discharge summary each time an inmate is moved from place to place within custody, as recommended by Dr Westmore.[372]

241. I note that CSNSW does not oppose examining ways to improve information sharing through the HPNF. While Justice Health was concerned to stress the importance of patient confidentiality, it agreed that effective communication between custodial staff and health staff should be encouraged.

242. Counsel for BB urged the court to consider a recommendation which would require CSNSW to "develop a specific process to assess the risk of harm of an inmate to others, including the risks posed by inmates with mental health issues, which takes account of historical information held by CSNSW, including any records of segregation".[373] I presume the specific process in mind would take into account information contained on the HPNF, but also require an officer to review information on the CSNSW system, including records in relation to segregation, and then independently assess "risk of harm". I have considered the proposal carefully and am concerned it could confuse the task correctional officers must undertake. The primary focus in relation to "risk of harm to others" should be the HPNF. I have not been convinced that segregation records would necessarily assist given the varied reasons for segregation.

243. Counsel for BB urged that a further recommendation in relation to the RAIT/RIT process be directed to reviewing whether inmates on an MNF in Darcy are currently being assessed every 24 hours by a RAIT. While I consider this best practice and in line with stated policy I have decided that the recommendation is not directly relevant to the deaths before me.

[372] Report of Dr Bruce Westmore, 18 June 2018, p 4 (V6 T107)
[373] Submission on behalf of BB p12 [70]

The need to improve conditions for Justice Health staff and visiting doctors

244. It became clear during the inquest that information sharing is only possible if it is efficiently stored and available to the nurses, general practitioners and psychiatrists who may need to access it. Staff must also be provided with an environment which is conducive to gathering information. If inmates are seen in chaotic or degrading circumstances it will be difficult to establish rapport and commence effective treatment. A number of information issues were revealed during the inquest.

Record keeping

245. Difficulties with the evidence-gathering process in respect of BB Justice Health files during the inquest means that it is not possible to say with any certainty what information was available to Justice Health staff at any given time.[374] Nevertheless, there was evidence that notes and/or other parts of BB files were often unavailable to Justice Health staff (including during a RAIT meeting).

246. Dr Spencer gave evidence that when assessing and/or reviewing a patient the psychiatrist undertaking the assessment would often not have access to a patient's notes, or if they did, generally just to the most recent volume.[375] Ms Munoz gave evidence that she did not have access to any of BB files other than the most recent volume during the RAIT meeting.[376] Mr Rec also gave evidence that he would generally only have the most recent part of a patient's file with him for the purposes of a RAIT interview.[377] It is also noted that Mr Rec recorded in the notes for the RAIT interview of 23 August 2012 that *"Old notes not available. CS New South Wales file in MHSU - D/C MHSU"*.[378]

247. Mr Trevor Perry gave evidence by way of a statement that consent to obtain information from each patient's community health provider is requested on reception.[379] If consent is given, the release of information (ROI) form is scanned and emailed to an ROI coordinator on completion of the reception screening assessment. This form is then sent to community health providers by ROI clerks at the MRRC. When the information is received from the community provider it is scanned into the Justice Health electronic Health System [JHeHS] and a waitlist appointment is made in the Patient Administration System for review by a clinician. The health information in JHeHS is available to all clinicians and can be viewed at any stage.

[374] See, for example, TS 28/8/18 pp 95.13-23 and 114-115
[375] TS 28/8/18 pp 82.29ff and 89.49
[376] TS 30/8/18 p 267.48
[377] TS 27/2/19 p 28.37-47
[378] Statement of Marco Rec dated 13 April 2016 (tab 87, p. 912)
[379] Statement of Trevor Perry dated 15 March 2018 at [5]-[6] (VA, tab 2, p.1)

248. It is unclear to what extent RAIT members and assessing clinicians currently have access to the JHeHS at the time of performing assessments. The evidence on access to computers was not entirely clear. Assistant Superintendent Tienstra gave evidence that Justice Health staff have access to a computer in the RAIT area.[380] Mr Rec gave evidence that a mental health nurse performing a mental health assessment may not always have access to a computer to check the JHeHS.[381] However, Dr Elliott gave evidence that he is never in a situation where he is conducting a mental health assessment of a patient without access to a computer.[382] Governor Woods provided evidence that a computer was installed in the RAIT interview room for custodial staff in May 2011 and whilst there is also a Justice Health Computer in the RAIT interview room that provides access to Justice Health specific platforms, he was not sure when it was installed.[383]

249. It is also unclear whether the current JHeHS system provides for easy access to summary information such as discharge summaries in one central location where it can be easily reviewed by busy clinicians. In the absence of this information, it is difficult to make specific recommendations in this regard. However, it is clear that a lack of access to this information was relevant to the events leading to DJ death.

250. Accordingly, a recommendation related to ensuring that such information is easily and quickly available is appropriate.

251. A different information management issue was raised in the RP inquest. Dr Dall gave evidence that had information about MA engagement with mental health services in the community been available to him at the time he conducted his assessment of MA in 2010, it may have made a difference to the course he took, however he could not say whether it would have been significant enough to have caused him concern about MA being required to be placed in a cell with another person.[384] In any event it was not available at the time. It is acknowledged that resources to chase community information can also be scarce.

Medication charts

252. The court heard that access to medication charts was less than optimal. Dr Spencer gave evidence that both in 2012 and today an assessing psychiatrist may not have access to a patient's medication chart.[385] Access to medication charts was, and is, particularly difficult in Darcy because medication charts are stored in the main clinic,

[380] TS 30/8/18 p 235.4
[381] TS 27/2/19 pp 10.13, 71.41 and 80.23
[382] TS 28/2/19 p 24.13
[383] Statement of Governor Woods dated 4 December 2018 (VA2, tab 8A, p. 1)
[384] TS 31/8/18 p371 onwards
[385] TS 28/2/19 p 83.9

which is some distance from Darcy,[386] as was seen during the view of the MRRC. Dr Spencer gave evidence that lack of access to medication charts means that practitioners cannot see the medication that a patient has been on or whether they have been taking it. Instead the practitioner is reliant upon a self-report.[387]

253. Ms Munoz gave oral evidence in the DJ inquest that Justice Health nurses participating in RAITs did not look at the medication charts, and did not have them available to them.[388] In response to questions by BB legal representative, Ms Munoz said that the RAIT team never, ever had access to medication charts.[389] However, she agreed that it would have been good to have had access to the medication chart when performing the task of the RAIT.[390] She gave evidence that if she had had access to the medication chart in this case, and it had indicated that BB had not taken his medication six times in the fortnight before he was seen by the RAIT, she would have told a psychiatrist straight away and would likely have told the other members of the RAIT team.[391]

254. In the RP inquest, Ms Freeman gave evidence that members of the RAIT team did not have access to medication charts from within MRRC.[392]

255. Mr Rec gave evidence in the DJ inquest that in Darcy medication charts are kept in the main clinic and that they were not available to RAITs in 2012.[393] Mr Rec gave evidence that access to the medication chart allows an assessment to be made of whether or not a patient is a good or bad historian. For example, BB had reported that he had been compliant with his medication, however his medication chart indicated that he had not. Mr Rec gave evidence that this was significant as it indicated that this would demonstrate that BB was a poor historian and that you could not believe everything that he said.[394] Mr Rec gave evidence that had he had the information from the medication chart that demonstrated that BB was non-compliant with his medication, he would have shared that information with the other members of the RAIT team.[395]

256. Perhaps most concerning, Dr Elliott also gave evidence that he did not have access to BB medication charts when assessing him in 2012.[396] In oral evidence he said

[386] TS 28/2/18 p 123.43
[387] TS 28/8/18 p 124.8ff
[388] TS 30/8/18 p 266.21
[389] TS 30/8/18 p 279.9
[390] TS 30/8/18 p 280.1
[391] TS 30/8/18 p 267.21
[392] TS 31/8/18 p 336.33
[393] TS 27/2/19 p 72.20
[394] TS 27/2/19 p 59.10ff
[395] TS 27/2/19 pp 48-49 and 59.29
[396] Supplementary statement of Dr Gordon Elliott dated 17 August 2018 at [27] (tab88A, p.920K).

that it was common not to have access to medication charts, describing it as "routine".[397] Dr Elliott said that this was a problem in BB case because it meant that he was unable to see that BB had been refusing his antipsychotic medication.[398] He gave evidence that the refusals indicated on BB medication chart were significant in that they would have demonstrated to him that BB was non-compliant and that the idea of increasing his medication was redundant or ineffective. When asked whether that information would have weighed heavily enough that it may have affected the outcome of his decision on the day that he assessed BB he responded *"I mean it's fundamental when you have got someone who, I think, has got a psychotic illness that is not taking any psychotic medication"*.[399] Dr Elliott gave evidence that lack of access to medication charts was a problem which needed to be fixed, but that this was nearly the case in that access to an electronic medical record would solve the problem, which he understood was coming to Justice Health.[400]

257. There can be little doubt that lack of access to BB medication chart was significant in the DJ inquest. It is unacceptable that psychiatrists such as Dr Elliott are routinely assessing patients in the absence of information as fundamental as that recorded on medication charts. Until electronic medication charts are available, urgent action ought to be taken to ensure that medication charts are available to assessing clinicians and Justice Health staff members participating in a RAIT.

258. I note that Justice Health did not support a recommendation in this area. Justice Health maintains the most effective way of addressing multi-point access to medication charts is an electronic Medication Management (eMM).[401] This may very well be the case, but it is some years away from implementation.[402]Justice Health also observed that coronial recommendations made subsequent to the death of DJ and RP have been targeted at training in relation to medication administration requirements. This is to be applauded. However, I remain of the view that medication charts should be available to RITs/RAITs and to mental health nurses and psychiatrists conducting mental state examinations. If this cannot be achieved through an electronic system for some years, a temporary solution must be found.

Physical environment

259. In his statement dated 17 August 2018, Dr Elliott described the environment where assessments were conducted in Darcy in 2012 as follows:

[397] TS 28/2/19 p 20.50
[398] TS 28/2/19 p 21.7
[399] TS 28/2/19 p 21.34
[400] TS 28/2/19 p 21.45 and 36.12
[401] Submissions on behalf of JHFMHN [58]
[402] Submissions on behalf of JHFMHN [58]

"The table [where assessment were conducted in 2012] is surrounded by the safe cells with their heavy Perspex doors. The cells themselves were noxious environments, being noisy both day and night, and pungently malodorous as a result of particular inmates smearing urine and faeces all over the walls, door and camera units, or flooding the cells with water from the toilet. Also, there was usually a small number of protection inmates circulating in this area hence there was minimal privacy. The assessments also frequently had to take place amidst the shouting and banging of inmates in the safe cells demanding to see the psychiatrist."[403]

260. Dr Spencer gave evidence about the area in which RAIT assessments and mental health assessments are conducted in Darcy. She agreed that Dr Elliott's description of the environment in his statement was consistent with her own experience.[404]

261. Assistant Superintendent Tienstra gave evidence that the area is always noisy, extremely noisy, with yelling, screaming abuse and a constant smell.[405]

262. Dr Elliott gave evidence orally that the environment in Darcy would be considered abhorrent in a mental health unit of a public health hospital where mental health assessments are undertaken, and this environment impedes an ideal mental health assessment.[406]

263. Dr Westmore gave similar evidence about the effect of a noisy environment on an ideal mental state examination.[407]

264. Ms Freeman described the physical environment as at the MRRC in 2010 as being a very difficult environment to work in.[408]

265. Assistant Superintendent Lockwood described the environment where the RAIT interviews are conducted as "putrid".[409] He gave evidence about the noise in the area and said that it does make it hard to do the task he is required to do in the RAIT, with the banging and the screaming.[410]

266. Mr Evans gave evidence that in 2010 the environment where the RAIT's were conducted was not a professional environment, not least because it was hard not to be distracted by the noise and other distractions such as views out into the wing where there were semi

[403] Supplementary statement of Dr Gordon Elliott dated 17 August 2018 at [10]-[16] (tab88A, p.920B).
[404] TS 28/8/18 p 82.6
[405] TS 30/8/18 p 234.40ff
[406] TS 28/2/19 p 42.9
[407] TS 28/2/19 p 57.20
[408] TS 31/8/18 p 346.46
[409] TS 31/8/18 p 357.16
[410] TS 31/8/18 p 358.30

and sometimes fully naked people in the cells. Mr Evans gave evidence that he has since transferred to another correctional centre where there is a professional interview room which provides the person being interviewed with dignity – they come to the room and sit down in an office space.[411] Specifically, he described the first RIT interview that he conducted at Cessnock Correctional Centre, being a maximum security environment, as being like a job interview in a professional environment with a desk and computers.[412]

267. Evidence was received from CSNSW that a building project is currently underway at the MRRC.[413] Specifically, Mr Wayne Taylor, General Manager of the Prison Bed Capacity Program, identified key infrastructure and construction enhancements as follows:

    a. 4x110 modular cell blocks, which includes interview and medical dispensary rooms within the block;

    b. Satellite Health Centre, being a health centre situated in close proximity to the new accommodation to provide health services to the 440 bed expansion; and

    c. Offender Services and Programs Building (OS&P), which includes the construction of a building located in close proximity to the new accommodation blocks to provide OS&P to the expanded beds.

268. It was submitted by CSNSW, at the close of the inquest, that this evidence indicated that there would be sufficient accommodation and separate interview rooms to allow for the maintenance of privacy and dignity of inmates[414].

269. However, in my opinion it is unclear from that evidence whether there are plans to build any new areas specifically for the purposes of RAIT interviews. If that is not currently intended, it is appropriate that it be considered, given the evidence heard in these inquests, and the example provided by Mr Evans of RAIT interview spaces that provide dignity to the inmates involved.

The need to reduce pressure on medical and correctional staff at the MRRC

270. It is abundantly clear that there was and continues to be enormous pressure to move inmates through the reception area at MRRC. This pressure operates negatively.

271. Governor Woods provided evidence:

[411] TS 31/8/18 p 329.27ff
[412] TS 31/8/18 p 330.44ff
[413] Statement of Wayne Taylor dated 25 February 2019 (VA1, T8C)
[414] Submissions on behalf of CSNSW [58].

"MRRC is the largest centre in NSW with a maximum capacity of over 1199. It has the largest number and proportion of remand inmates in the state. The MRRC is the main reception for NSW receiving over 40 percent of all new receptions into the correctional system. The inmates are received from NSW police and courts."[415]

272. Dr Spencer gave evidence that there is huge demand on cells in the reception area in Darcy at the MRRC, because there are patients waiting in police cells to come into custody, so both Justice Health and CSNSW staff are very keen to move people out of Darcy as soon as possible. She described there being "huge pressure on Darcy".[416] Dr Spencer also gave evidence that the section of Darcy that is subject to clearance pressures is also the section of Darcy that inmates who are placed on an MNF/RAIT are sent to.[417] Dr Spencer also gave evidence around huge pressure on beds in the MHSU and in Hamden pods 17/18, both in 2012 and today.[418] Dr Spencer also made reference to CSNSW officers being under pressure to make sure there is enough room for new inmates.[419]

273. Assistant Superintendent Cullen gave evidence that those in the system are under pressure to move inmates around, particularly out of Darcy. He indicated that because Darcy is a screening area for inmates it was necessary to process inmates to make way for the next incoming inmate, so an attempt is made to move inmates as quickly and easily as possible to the other areas of the MRRC.[420] Assistant Superintendent Cullen also gave evidence that there was pressure to make one-out cells available, as there were very few one-out cells at the MRRC. Assistant Superintendent Cullen gave evidence that these pressures influence the RAIT decision-making process through unintentional pressure placed on Justice Health nurses to clearly look at an inmate's placement and to make sure that an inmate really needs to be placed in a one-out cell.[421]

274. Ms Cheung gave evidence that pressure on bed space in Darcy and elsewhere was something she was aware of and that, as at 2012, while an attempt was made not to allow it to affect the RAIT decision making process, in her view, it was inevitable that it impacted in some way.[422]

275. Assistant Superintendent Tienstra gave evidence that there was always pressure to move inmates on because of the numbers and, while management never gave

[415] Statement of Governor Woods dated 4 December 2018 (VA2, tab 8A, p. 1)
[416] TS 28/8/18 p 83.20-47
[417] TS 28/8/18 p 87.43
[418] TS 28/8/18 p 87-88
[419] TS 28/8/18 p 118.45
[420] TS 29/8/18 p 153.2ff
[421] TS 29/8/18 p 154
[422] TS 29/8/18 p 197.34

instructions to clear someone if he wasn't comfortable to do so, he also knew if one inmate was cleared there were two more waiting to come in. He also gave evidence that the pressure is much worse now than it was in 2012.[423]

276. Ms Munoz gave evidence that there was always pressure to clear cells because police cells are full.[424]

277. Mr Evans gave evidence that in 2010 there was an underlying pressure to clear inmates from Darcy and that he recalled being asked the question "how many did you clear today?". He also indicated that it was not unusual to hear about the pressure on the system directly, for example by hearing that all of the safe cells were full and that there were a large number of inmates at Surry Hills Police Station waiting to come to the MRRC.[425]

278. Ms Freeman gave evidence that there was pressure upon all services within the system to clear people, and that if you did not clear people, others were sitting in police cells, which was a worse environment than being at the MRRC. She gave evidence that the pressure had no bearing for her in terms of the RAIT decision making process. However, she did say that she left Justice Health in 2011 because she was seen as being someone who was very cautious who did not like to clear people and did not like to put people in a normal cell placement, and was often reprimanded for that. She gave evidence that she was concerned that she was fairly newly qualified to mental health and had not had the opportunity to observe or have any formal orientation and that she got to the point where she felt that she was unable to work in an appropriate manner and for that reason left Justice Health.[426]

279. Assistant Superintendent Lockwood gave evidence that there was pressure to clear the safe cells in 2010 as beds were needed and there were no vacancies.[427]

280. Mr Rec gave evidence that there was a demand for safe cell beds in Darcy because they were very overcrowded and if they block up in Darcy they will block up in Surry Hills Police Station. The only effect that Mr Rec identified this may have had on the RAIT process was officers verbalising that they needed to get a particular inmate out of a safe cell.[428] Mr Rec appeared to say that this pressure was continuing when he retired in 2017.[429]

[423] TS 30/8/18 p 235.16
[424] TS 30/8/18 p 269.38ff
[425] TS 31/8/18 p 331.25ff
[426] TS 31/8/18 p 347.24ff
[427] TS 31/8/18 p 358.13
[428] TS 27/2/19 p 61.20ff
[429] TS 27/2/19 p 70.45ff

281. Dr Elliott gave evidence that pressure for one-out cells was "always lurking over all of us in our decision-making", that there is just not that many one-out cells and so decisions are being made based on practical considerations.[430] Dr Elliott said in oral evidence that his role as an assessing psychiatrist in Darcy was "really to keep Darcy moving".[431] He said that the current situation was no better than it was in 2012, in fact it is currently worse. He told the court,

> *"there's 50 people on the waiting list for the screening unit and its taking weeks to get in there. So those people are now languishing in regional gaols without regular psychiatric care and amongst those are seriously mentally ill or alternatively, they're backed up in Surry Hills Police Station with nothing. So there are practical considerations that you need to consider about where these people go and that's only gotten worse since 2012. It's – you know, going back to Darcy, a few weeks ago it's significantly worse."*[432]

282. The "Visual Management Board" in Darcy,[433] indicating the daily inmate intake and movement of inmates, including a daily target for number of inmates to be cleared, seen during the view of Darcy at the MRRC, provided a stark visual representation of the pressures described in the evidence above.

283. Dr Westmore gave evidence that while witnesses who referred to the pressure to clear beds in Darcy indicated that it had not affected their decision-making processes, in his view, that pressure had obvious potential to compromise care.[434] Dr Westmore also characterised this as a professional risk due to the chance of making rushed or incorrect decisions because of pressure to move people on.[435]

284. In the *Inquest into the death of Fenika Junior Tautuliu Fenika (Junior Fenika)*, Acting State Coroner O'Sullivan made a recommendation to the Minister for Corrections, the Minister for Health and the Commissioner of Corrective Services 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."*

[430] TS 28/2/19 p 20.19
[431] TS 28/02/19 at p 17.4
[432] TS 28/2/19 p 18.9 onwards
[433] Statement of Michael Green dated 22 February 2019 at [31]-[34] (VA2, tab 8B)
[434] TS 28/2/19 p 58.35
[435] TS 1/3/19 p 19.1

285. Evidence was received in the present inquest that this recommendation was considered at the Management of Deaths in Custody Committee Meeting on 25 September 2018 and that it would be considered at a Joint Senior Level Working Group between Justice Health and CSNSW, which first met on 27 February 2019.[436] There was also evidence that as at 27 February 2019, a briefing note, together with a draft letter prepared by CSNSW to the Attorney General was under consideration by the Minister for Corrections, in relation to the implementation of a number of coronial recommendations, including those of Acting State Coroner O'Sullivan in the *Inquest into the death of Fenika Junior Tautuliu Fenika (Junior Fenika)*.[437]

286. A review of the kind recommended Acting State Coroner O'Sullivan is supported in light of the evidence in the present inquest. However, the evidence in this inquest went to the particular pressure to clear inmates from Darcy generally, including inmates in Darcy who were there for mental health purposes. For example, Mr Green stated that resourcing issues arising from mental health and/or primary health can result in "inmate blockage" and Darcy being "jammed".[438] In these circumstances a recommendation specifically directed to a review of the availability of cells and resources in Darcy is appropriate.

287. It may be that any such review could be conducted with the review recommended by Acting State Coroner O'Sullivan, assuming that review has not commenced since the recommendation was considered on 27 February 2019.

288. Submissions provided by Justice Health at the conclusion of proceedings urge against a recommendation aimed at specifically reviewing the need for assessment cells and other resources at the MRRC. It states "CSNSW has confirmed that 50 additional assessment cells will be made available within the 440 bed expansion to the MRRC due to be delivered in March 2021.The Network will continue to work collaboratively with CSNSW to develop a service model for those additional beds".[439] It was submitted that this and the possibility that improved patient flow systems may be developed should allay concerns.

289. The submissions provided by CSNSW at the conclusion of the inquest also argued that such a recommendation was unnecessary because, in view of the expansion project at MRRC, "the desired outcome had already been achieved"[440]. It was further submitted that the Commissioner had already identified the pressing need for expansion, which will

[436] Exhibit 4, letter from Department of Justice to the Crown Solicitor dated 27/02/19
[437] Ibid
[438] Statement of Michael Green dated 22 February 2019 at [22]-[24] and [31] (VA2, tab8B); see also supplementary statement of Trevor Perry dated 27 February 2019 at [6], [8] and [12] (VA, tab 3C)
[439] Submissions on behalf of JHFMHN [54]
[440] Submissions on behalf of CSNSW [49].

include an increased number of assessment and other cells[441]. In this regard, I note the following evidence of Mr Wayne Taylor, General Manager, Prison Bed Capacity Program, CSNSW:

> *"The project scope considered the management of at-risk prisoners with an increase of 55 CCYV monitored beds. The exact design as to how many of these beds will be assessment as high risk or step down moderate risk is still under review as part of the final project development"*[442].

290. I have considered the matter carefully and my concerns remain. In my view the situation is urgent. Numerous witnesses discussed the terrible pressure within the system, which meant that inmates were backed up in police cells and arrived at MRRC to experience further overcrowding and delay. Access to medical services can involve long waiting times and the options remain limited. Changes to the physical environment in 2021 may improve the current situation, but more needs to be done and sooner.

Conclusion

291. One must not forget the violent and frightening deaths these two men must have suffered while living under the care of this State. While the deaths under investigation occurred some years ago, the background pressure which affects cell placement decisions and the medical management of mentally ill patients appears to remain today. In my view it is a significant problem.

292. I offer my sincere thanks the many witnesses who came to court and relived difficult events and decisions. I was enormously impressed with medical professionals and custodial staff who spoke with great openness about the conditions in which they work and the difficult decisions they face. The transcript may not reflect the palpable sense of despair some witnesses communicated when describing trying to treat patients in such degrading and stressful conditions. I thank them for their honesty.

293. I thank those assisting me, Mr N Kelly of counsel and Ms K McCrossin for their enormously hard work in the preparation of this inquest. I also thank Detective Senior Constable King and Detective Senior Constable Pratap for their assistance in this inquest.

294. I close this inquest.

[441] Submissions on behalf of CSNSW [54].
[442] Statement of Wayne Taylor dated 25 February 2019 (VA1, tab 8C)

Findings

295. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

DJ

The person who died was DJ

Date of death

He died on 1 September 2012

Place of death

He died at cell 407 of Pod 16 of Hamden Block at the Metropolitan Remand Centre (MRRC) in Silverwater, NSW

Cause of death

He died from neck compression.

Manner of death

He died of injuries inflicted by his cellmate.

RP

The person who died was RP

Date of death

He died on at some time between 3.25pm on 23 April 2010 and 6.15 am on 24 April 2010

Place of death

He died at cell 108 of Pod 10 of Pod 10 of Fordwick Block at the Metropolitan Remand and Reception Centre (MRRC) in Silverwater, NSW.

Cause of death

He died from fatal pressure to the neck. An autopsy revealed extensive haemorrhage of the soft tissues of the neck with fractures of the hyoid bone and cricoid cartilage

Manner of death

He died of injuries inflicted by his cellmate

Recommendations pursuant to section 82 *Coroners Act 2009*

296. For reasons stated above, I make the following recommendations:

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

A review be carried out urgently of the need for assessment cells at the MRRC and the extent to which a lack of access to such cells and other resources for assessment including health services provided for the purposes of assessment, are delaying the intake of new inmates.

That consideration is given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in NSW in a secure health facility rather than in the general prison population

To the Minister for Corrections and the Commissioner of Corrective Services

As part of the building project currently being undertaken at the MRRC the creation of a new space to conduct RAIT assessments and mental state examinations be considered, such space to be appropriate for the proper conduct of RAIT assessments and mental state examinations.

To Justice Health

Steps be taken to ensure that inmates' medication charts are routinely available to RITs/RAITs and mental health nurses and psychiatrists conducting mental state examinations of inmates.

File keeping practices be adjusted to ensure that discharge summaries received through the request for information process be collated and held together in one part of the file and that this part of the file be moved from any closed volume of a file into any new volume of a file opened so as to be easily accessible to those conducting mental state examinations and RITs/RAITs.

To the Joint Working Group between Justice Health and CSNSW

Existing policies governing the exchange of information between Justice Health and CSNSW be amended to ensure that health information relevant to an inmate's risk of harm to others be included on the HPNF, or some other form, and that this information remain current and available to any CSNSW officer making cell placement decisions.

Following any amendment, consideration is given to implementing training for staff involved in the RIT/RAIT process in relation to purpose of the HPNF

Magistrate Harriet Grahame
Deputy State Coroner
4 July 2019
NSW State Coroner's Court, Lidcombe