STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Glen Russell
Hearing dates:	28 – 30 August 2017 26 – 27 February 2018
Date of findings:	26 June 2018
Place of findings:	Newcastle Coroners Court
Findings of:	Magistrate Stone Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody; asphyxia; adequacy of intake screening and assessment; workload and staffing; recommencing medication prescribed in the community; monitoring of mental health of inmates; compliance with Corrective Services policy and procedure
File number:	2015/125390

Representation:	Counsel Assisting the Coroner: Mr Peter Aitken of counsel, instructed by Ms Jessica Natoli, Crown Solicitor's Office Glen Russell's family (Ms Narelle Jarvis and Ms Donna Russell): Mr David Evenden, Solicitor Advocate, instructed by Ms Helen Cooper, Legal Aid NSW Commissioner of Corrective Services NSW: Mr Ben Fogarty of counsel, instructed by Ms Janet de Castro Lopo, Office of the General Counsel, NSW Department of Justice Justice Health & Forensic Mental Health Network: Mr Patrick Rooney of counsel, instructed by Mr Nicholas Regener, Makinson d'Apice Lawyers Ms Katherine Redfern: Mr Robert Reitano of counsel, instructed by Mr Michael Jaloussis, McNally Jones Staff Lawyers Mr Marc Bender, Mr Stephen Neal and Ms Susan Jedrzejczyk: Mr Brent Haverfield of counsel, instructed by Mr Ken Madden Ms Julie Wells, Ms Kate Quarello and Ms Sue-Anne Henderson: Ms Pat Robertson, Solicitor Advocate, NSW Nurses and Midwives' Association Ms Rhonda Sharpe: Mr Matthew Byrne, Solicitor Advocate, NSW Nurses and Midwives' Association
Non publication order:	Pursuant to section 74(1)(b) of the *Coroners Act 2009,* I order that there be no publication of the documents and identified extracts of documents that are set out in the minutes tendered in the inquest (see court file for full list). Pursuant to section 65(4) of the *Coroners Act 2009,* I order that access not be given to any person seeking access to coronial records, unless the Commissioner of Corrective Services NSW has been given notice and an opportunity to be heard, to the documents and identified extracts of documents that are set out in the minutes tendered in the inquest (see court file for full list).

Findings:	**The identity of the deceased** The deceased person was Glen Allen Russell **Date of death** Mr Russell died on 27 April 2015 **Place of death** Mr Russell died in cell 15, G3 Pod, at Cessnock Correctional Centre, Cessnock **Cause of death** The medical cause of his death was asphyxia arising from neck compression. **Manner of death** Glen Russell died after using torn or cut up pieces of a bed sheet to make a ligature, which he tightened around his own neck while lying on his bed with the intention of ending his life.

Recommendations:	To Justice Health: I. That the current template for the "Reception Screening Assessment" form, in circumstances where the patient answers "yes" to any of the 3 mandatory questions under the heading "Suicide risk assessment", be amended to also mandate that the clinician record answers to the further clarifying questions set out under that mandatory question; II. That the current proposed clarification of the patient appointment priority rating categories from 1 – 5 on the "Patient Administration System" include clarification of the rating categories so far as they apply to patients requiring mental health assessments. To the Commissioner for Corrective Services: I. That the current ongoing revision of the Operations Procedures Manual (or its replacement, as the case may be) include clarification to Corrective Services officers on the interaction between (a) the safety and security requirements for officers opening cells in response to a cell alarm in maximum security centres and (b) the duties of a first responding officer in a potential death in custody situation. II. That consideration be given to amending the current CSNSW "Intake Screening Questionnaire", to ensure that currently consolidated questions concerning self-harm and suicide (both current plans and previous acts/attempts) are separated into separate questions as follows: • Do you have any current plans to hurt yourself? • Do you have any current plans to end your life? • Have you ever previously tried to hurt yourself? • Have you ever previously tried to end your life? III. That consideration be given to amending the current consolidated question in the CSNSW "Reception Checklist" concerning "current thoughts of self-harm/suicide" to have two discrete questions, one addressing current thoughts of self-harm and one addressing current thoughts of suicide. (I note from the Commissioners submissions that this has already been revised). Deputy State Coroner R G Stone Coroners Court Newcastle

The Coroners Act 2009 (NSW) *in s 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Glen Allen Russell.*

Introduction:

1. Glen Allen Russell died on 27 April 2015, aged 32 years. As he was on remand at Cessnock Correctional Centre at the time of his death, an inquest is required to be held pursuant to sections 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009 (NSW)* ("the Act").

The Inquest:

2. Section 81 of the Act requires a coroner to make findings as to:

   - the identity of the person who has died;
   - the date and place of the person's death; and
   - the manner and cause of the death.

3. In addition, under s 82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future.

4. As Glen was in custody at the time of his death, the responsibility for ensuring he received adequate care and treatment rests with the State. For this reason, whenever a person dies in custody, an inquest is required to be held to assess whether the State has discharged its responsibilities.

Social History:

5. Glen Russell was born on 4 March 1983 and grew up in Woodberry NSW and various other locations in the Newcastle area. He was one of 5 children to his mother Narelle Jarvis.

6. When Glen was ten years old he was sexually assaulted by a male adult, Errol McMinn. Subsequent issues as a juvenile saw Glen spend time in Department of Community Services ("DOCS") custody, juvenile detention at Kariong and Worimi, refuges and boys' homes. He began to commit crimes such as break and enters and robberies.

7. When he was a teenager, Glen starting experimenting with various substances. He started using heroin at age 17, developed mood swings and anger and was subsequently diagnosed with schizophrenia. He was later placed on methadone to deal with his heroin addiction. Glen's mother believes that he used drugs to take away the pain of his sexual assault.

8. At the age of 15, Glen had a daughter, Ashleigh, and more recently fathered a son, Aliza, with his former partner, Meleka Drew. Prior to his death he had formed a relationship with Melissa Te-Wake, who had children of her own.

Criminal Justice History

9. As an adult, Glen continued to be involved in criminal activity, spending various periods in custody. Justice Health & Forensic Mental Health Network ("Justice Health") records show periods in custody in 2002, 2007, 2008, 2009, 2010, 2011, 2013 and 2014.

10. In April 2010, Glen was in custody in the Mid North Coast Correctional Centre. An Incident Report dated 19 April 2010 notes that Glen reported that an "old wound" had opened up on his left arm and that, while he made no admission to deliberately opening it up, he was placed on a Mandatory Notification with camera cell observation. On 20 May 2010, an Incident Report records that a phone call was received from a person claiming to be Glen's uncle, who said that Glen had talked about suicide in the days before coming into custody. Glen was placed in a two-out cell.

11. In a Justice Health progress note dated 25 May 2010 Glen was asked about some sutures to his left wrist and claimed to have put his hand through a window. The reviewing clinician described the wound as a "definite slash-up".

12. In November 2012, Glen was admitted back into custody. He was placed on a Risk Intervention Team ("RIT") order briefly after being "verbally aggressive and self-harming in the police cells under the influence of heroin". A mental health assessment was conducted on 5 December 2012 in which Glen claimed to have had schizophrenia as a child. His claim that he heard voices was seen as warranting an appointment with a psychiatrist. He was not assessed as being in an at risk mental state.

13. On 5 November 2013, Glen was released from custody. In December 2013 he met Helen Fielder-Gill, a post-release and drug and alcohol manager with the Samaritans Foundation, who helped him, set up a house in Bull St, Newcastle, and with other issues relating to his reintegration and management in the community.

14. On 4 May 2014, when admitted into custody to serve a short sentence at the Mid North Coast Correctional Centre, Glen was assessed by Justice Health staff as being at risk of self-harm. He was made the subject of a RIT management plan, and was put in a safe cell with 24 hour CCTV observation.

15. Following a review on 10 May 2014, at his own request and unable to guarantee his own safety, Glen was kept in the observation cell until his release from custody on 16 May 2014. A case note on the Offender Integrated Management System ("OIMS") dated 10 May 2014 records that "this appears to be because he does not want to immerse himself back into the gaol culture. Inmate appears to be wanting to stay away from gaol influences until release."

Events Prior to Glen's Return to Custody in March 2015

16. Sometime before he returned to gaol in March 2015, Glen self-harmed by making what were described by Ms Fielder-Gill as "big cuts on his arm" which were seen by his GP, Dr Singh, with Samaritan intervention. While no specific date is recorded it can be gleaned from various police and ambulance records that this is likely to have occurred in February 2015.

17. On Sunday 22 February 2015, at about 7.30pm, police attended the Mater Hospital after Glen told staff that he had been stabbed by an unknown person. Shortly before 1.00am

the same night, police were called to a domestic incident. They arrested Glen, who told them, "give me 5 minutes alone and I'll be dead. I was coming back to kill myself". Glen then told police that he had cut his arm earlier in an attempt to kill himself however had claimed he had been stabbed to avoid being scheduled. Glen was taken to John Hunter Hospital, where his wounds were treated. He was ultimately detained by police and conveyed to the Calvary Mater Hospital for possible scheduling.

18. Glen was assessed as a mentally disordered person by Dr Josef McDonald, who stated: "Ongoing suicidal ideation with the means of 'jumping in front of a train'. Guarded in response to questions regarding psychotic symptoms." Dr McDonald concluded: "Ongoing risk of harm to self and would benefit from ongoing assessment to ensure safety."

19. Glen was later released by the hospital without police being notified.

20. On Saturday 28 February 2015, Glen was arrested and charged with breach of an AVO that was current, involving Ms Te-Wake. The same day at about 12.39pm, Glen was bail refused at Newcastle Police Station by Sergeant Checkley, on charges of contravene AVO, drive disqualified, resist arrest and assault. The Custody Management Record from that day, created at 10.45am by Sergeant Checkley, noted on page 2, "left lower arm bandaged after a self-harm attempt". It further noted, "observed 5 open + stitched lacerations across inner forearm, self-inflicted 2 days ago".

21. The same day, ambulance paramedics examined Glen's arm injury at Newcastle Police Station. The Ambulance Service of NSW form describes "x7 lacerations of varying length and depth" with sutures already in place, greater than 48 hours old, with an unclear history. Glen is recorded as saying that he had punched or put his hand through a glass window, however the paramedic recorded that "wounds appear consistent with being self-inflicted".

22. Glen was admitted to the Calvary Mater Hospital Emergency Department at 7pm that night for examination, with the Discharge Summary recording a similar history of putting his arm through a window. Clinical notes queried if the wounds were self-inflicted and noted: "self-harm: at this time denied suicidal thoughts/plans/ideas" and "please reassess self-harm risk..."

23. A NSW Police document entitled Prisoners/Intoxicated Persons Transfer Note, completed by Sergeant Checkley and dated 28 February 2015, records various information including: "May be suicidal information from Wendy Harley carer of POI May inflict self-injury."

24. Glen was placed in Corrective Services NSW ("Corrective Services") custody to be taken to court the next day on 1 March 2015.

25. On Sunday 1 March 2015, Glen was bail refused at Newcastle Local Court on charges of contravene ADVO, drive whilst disqualified, resist arrest and assault, and was to be assessed by Justice Health and then brought to court the following day.

26. On 2 March 2015, Samantha MacCameron, a clinical nurse consultant from Hunter New England Health Forensic Services Court Liaison, faxed a request to Dr Singh for Glen's current prescribed treatment, noting that "I assessed the above client today in custody". Dr Singh's records show that a Health Summary Sheet was printed the same

day. Ms MacCameron subsequently made a statement in which she noted that Glen was referred to the Court Liaison Service by Corrective Services. She noted that his left arm was in a bandage, and stated that he admitted to having self-harmed in previous weeks. She conducted a mental health assessment which concluded that Glen was not at immediate risk of suicide or self-harm. Her report was provided to the court.

27. On 2 March 2015, Glen appeared before Newcastle Local Court on charges of contravene ADVO, drive whilst disqualified, resist arrest and assault. He was granted bail and was to return to court on 12 May 2015.

Return to Custody

28. On 6 March 2015 Glen was arrested on charges of break, enter and deprive person of liberty and other related charges at about 7.15pm and was subsequently bail refused. The NSW Police Custody Management Record reveals, in an entry recorded at 3.13am, that Glen was "moved to the hospital for treatment of his injuries", having come into custody "with a number of injuries to his face arm and legs he refused treatment by the ambulance officers". Glen was recorded as "returned to the charge room" in a further entry at 3.14am. The record also shows the comment, "prisoner has large open wounds to his left arm indicating previous self-harm".

29. Glen was bail refused on 7 March 2015 and his matter was stood over until Monday 9 March 2015 at Newcastle Local Court.

30. On 8 March 2015, Glen was transferred to Cessnock Correctional Centre ("Cessnock CC") on a remand warrant.

31. The last OIMS case note on file for Glen is dated 21 January 2015. There is no record of Glen having made any phone calls between 20 October 2014 and 27 April 2015 from Cessnock CC.

The Events of 27 April 2015

32. About 5.30am on 27 April 2015, Glen's cellmate, Inmate Baglee, was taken from cell 15 to Toronto Local Court for a court appearance.

33. CCTV from Cessnock CC shows Glen at about 3.20pm entering cell 15 and the door being secured behind him. Inmate Baglee had not yet returned from court, and it is significant that this was the first time since entering custody that Glen had entered lock-in alone. CCTV confirms that, between 3:20pm and the return of Inmate Baglee from court, no other person approached the door of cell 15 or entered the cell.

34. At about 7.50pm Inmate Baglee was returned to cell 15 by Casual Correctional Officer Marc Bender ("Correctional Officer Bender") and First Class Correctional Officer Kathryn Redfern ("Correctional Officer Redfern").

35. The following summary of what occurred next is based on my observations of the CCTV footage played during the hearing of the inquest, the statements included in the brief of evidence and oral evidence given in the inquest. Within approximately three and a half minutes of entering the cell, Inmate Baglee used the cell alarm system (known as a "knock up") to contact Correctional Officers Redfern and Bender, who were in the Wing

Office. He said words to the effect of "my cellie's done himself in". Correctional Officer Bender asked, "are you joking?" and Inmate Baglee replied "no".

36. Correctional Officers Redfern and Bender left the wing office and ran to cell 15, arriving within around 30 seconds of the "knock up" occurring. They looked through the cell door window and saw Glen lying face down on his bed and Inmate Baglee pacing up and down in the cell. Correctional Officer Redfern radioed for the assistance of the Night Senior, the Assistant Superintendent and Justice Health nurses.

37. Senior Correctional Officer Stephen Neal ("Correctional Officer Neal") arrived less than two minutes later and Correctional Officer Bender unlocked the cell. Inmate Baglee walked out of the cell and into the pod. The correctional officers looked into the cell, but did not enter the cell at that stage. Correctional Officer Neal observed something white around Glen's neck and left to go and get a 911 Rescue Tool. Around one minute later, Assistant Superintendent Jedrzejczyk, Justice Health registered nurse Julie Wells ("Nurse Wells") and Correctional Officer Neal arrived and Nurse Wells and Correctional Officer Neal entered the cell.

38. Correctional Officer Neal observed a white cord around Glen's neck. He saw it was very tight and digging into the skin. He cut the cord about the back of the neck area and, as he did so, noticed that Glen's body was stiff. He could not see a knot in the cord. He saw some blood spots on the floor, a razor blade on the bed and he picked up a suicide note written by Glen that was on the bed next to him. It was apparent that Glen had used torn or cut up pieces of a bed sheet to make a ligature and tighten it around his neck.

39. Nurse Wells and First Class Correctional Officer Scott Eastwood ("Correctional Officer Eastwood") rolled Glen onto his back and Nurse Wells attempted to apply oxygen to him however he was unresponsive and she stated, "he's too far gone." Correctional Officer Eastwood noted that Glen's body was cold and stiff. At about 8:14pm ambulance personnel attended. At about 8:16pm the emergency cell alarm system or "knock up" for the cell was checked and found to be functioning. All persons exited the cell and the cell door was closed.

40. At about 9:25pm Inspector Tracey, Sergeant Scraysbrook and Constables Kirby and Proctor from Central Hunter Local Area Command attended the scene. Detectives Cooper and Ferguson also attended. No suspicious circumstances were noted. The suicide note was opened by police. It was addressed "to my beloved wife, Melissa Te- wake, next of kin". The note stated:

    > "hay sweetheart, I'm so sorry about everything, I pray that you forgive me for doing this. I have to do this, I can't do this no more. The voices, no sleeping much and not being able to see or talk to you. Always no (sic) I will be with you in your heart and mind. Love you Melissa good by (sic) and God bless you and the kids. Love your Dead Man. Glenn Russell."

Autopsy Evidence

41. An autopsy report dated 24 June 2015 was prepared by Dr Allan David Cala, a senior staff specialist in forensic pathology, located at the Department of Forensic Medicine, Newcastle. Based on his experience and training his opinion was that Glen died on 27 April 2015 at the Cessnock CC, Alunga Avenue, Cessnock, and that the cause of death was asphyxia arising from neck compression. Under the heading "Comments" the doctor provided the opinion that it appeared Glen "was face down during the application of the ligature around his neck. There was no evidence that the deceased was suspended at any time and appears to have committed this act whilst on the bed. The face down position may have contributed to the death by partially occluding the external airway (mouth and nose)." He further noted that the toxicological analysis showed no alcohol in the blood. Methadone, mirtazapine and quetiapine were detected in the blood at therapeutic levels although the methadone level was consistent with chronic use.

42. In a further letter to the Crown Solicitor's Office dated 11 July 2017, Dr Cala confirmed that Glen's injuries were consistent with self-inflicted ligature strangulation. Further, he provided the opinion that the findings of being stiff and cold to touch suggested that Glen had died much earlier than the time at which Corrective Services and Justice Health staff entered the cell. He said if Glen had died just prior to that he would have expected the body to feel warm to touch, have no stiffening and be entirely flaccid. He said, "I would completely discount death occurring 6 to 10 minutes prior to being found if the body was described as being stiff and cold to touch". The doctor's opinion as to cause of death, his comments that form part of the autopsy report and his additional comments referred to in the letter of 11 July 2017 are uncontested.

43. Accordingly, the identity of the deceased, the date and place of death, and the medical cause of death are known, and findings will be made at the conclusion of this inquest consistent with the opinion of Dr Cala.

Analysis Regarding Issues of Concern:

44. The inquest focussed on seeking to understand the manner of Glen's death, which involved exploring whether certain aspects of the management and care of Glen after he was received into Corrective Services custody may have contributed to his death occurring, or whether there was scope for procedures to be improved.

Helen Fielder-Gill:

45. Before dealing with these issues, it is relevant to note that one of the first people called in the inquest was Helen Fielder-Gill. She had first met Glen in December 2013 when he came to Friendship House, a residential program for people getting out of goal. Glen had been released to parole on 5 November 2013, after serving a sentence of almost one year for a break, enter and steal offence. By that stage Glen was 30 years old and had spent around 11 years of his adult life in gaol.

46. Although Glen spent a further 2 periods in custody after this, he continued to have an association with Ms Fielder-Gill and she continued to assist him, including arranging for him to move into his own accommodation in Mayfield.

47. Glen had lost contact with his mother since his early twenties, however ran into her in or about July 2014. This became a positive experience and there was considerable contact after this date not only with his mother but also his sister. He was observed, according to his mother, to be happy that he had a family and a place to call home.

48. By the end of 2014, Glen was in a relationship with Ms Te-Wake and was living with her. On 17 February 2015, an Apprehended Domestic Violence Order ("ADVO") was taken out against Glen. This occurred after Ms Te-Wake's daughter told police that Glen had assaulted Ms Te-Wake (Ms Te-Wake denied that an assault took place). In any event, Glen was charged with common assault and the ADVO prohibited him from contacting or approaching her and certainly from living with her. Despite the ADVO, they continued living together.

49. A couple of weeks before Glen returned to custody, DOCS officers came and took some of Ms Te-Wake's children away from the Mayfield home. Ms Fielder-Gill described this as a tipping point for Glen and said that his world was going out of control. This provides some context regarding the issue of Glen self-harming prior to going back into custody. Glen admitted to Ms Fielder-Gill that he had self-harmed.

50. After Glen had gone back into custody, Ms Fielder-Gill rang Cessnock CC and advised them that Glen was not in a good way; she believes that she may have informed the correctional centre that Glen had been self-harming (although due to the amount of time that had passed she was not sure of the exact words she used). She was reassured by the officer that she spoke to over the telephone that Glen was being held in a "two-out" cell. The inference I draw is that the officer she spoke to was indicating a belief that this would offer some kind of protection in that a cellmate could alert officers to any issues.

51. There are no notes recording either this conversation or any response by officers within Corrective Services and certainly there is no evidence of any steps being taken to draw this concern to Corrective Services officers or Justice Health nurses.

<u>The adequacy of the intake screening and assessment of Glen by Corrective Services and Justice Health personnel during his reception into Corrective Services custody and into Cessnock Correctional Centre on 7 and 8 March 2015.</u>

Screening & assessment conducted by Corrective Services

52. I will first deal with the adequacy of the screening and assessment performed by staff employed by Corrective Services. The officer in charge of the coronial investigation, Detective Sergeant Babb, gave evidence and was asked about the Prisoners/Intoxicated Persons Transfer Note dated 7 March 2015, that accompanied Glen when he was transferred from police custody into Corrective Services custody. That document contained information in terms, "may be suicidal. Information obtained from Wendy Harley, carer of POI. May inflict self-injury". Detective Sergeant Babb stated that he had made enquiries and had ascertained that this information was first entered into the police COPS system in 1997 or 1998, and was populated into the Prisoners/Intoxicated Persons Transfer Note from the "warnings" field in COPS along with any and all other warnings with respect to Glen.

Screening by Correctional Officer Sylvester at the Newcastle Police Cells

53. When he was first handed over into Corrective Services custody, Glen was assessed by Correctional Officer Darren Sylvester ("Correctional Officer Sylvester") in the Newcastle Police Cells at 4:10am on 7 March 2015. Correctional Officer Sylvester's evidence comprised two statements dated 21 October 2016 and 11 May 2017. Correctional Officer Sylvester did not give evidence before the inquest as his solicitors made an application that he be excused on medical grounds, which was granted by me.

54. Assistant Superintendent Darren Kearney ("AS Kearney") gave oral evidence in Correctional Officer Sylvester's absence about the procedures that applied as at March 2015 with respect to the initial reception of inmates into Corrective Services custody. He provided information about the process for transferring inmates from police custody into Corrective Services custody and agreed that, at that time, certain records are provided by police to the screening Correctional Officer (Correctional Officer Sylvester), including the Custody Management Record and Prisoners/Intoxicated Persons Transfer Note.

55. AS Kearney said that the screening correctional officer is required to conduct a strip search and a visual check for signs of self-harm. He identified that the version of the police Custody Management Record included in Glen's Corrective Services Case Management File was missing page 2. Page 2 recorded a police observation in these terms: "prisoner has large open wounds to his left arm, indicating previous self-harm". Assistant Superintendent Kearney said that he would have expected that an officer familiar with these forms, if he had noticed it was missing a page, would have chased it up.

56. One of the forms completed by Correctional Officer Sylvester during the reception process was the Inmate Identification and Observation Form ("IIO"). At page 4 of that form the pro forma question "have you previously attempted suicide or self -harm" is ticked "no". At page 5 of that document the pro forma question "does the offender have neck/wrist scars that suggest self-harm" is also ticked "no" (I note that a photograph taken of Glen's arm after he died, tendered in the inquest, clearly shows scars on Glen's wrists and that Correctional Officer Sylvester in his second statement said he had questioned Glen about those scars and he had replied, "it was a long time ago when I was young and stupid"). The same page records "graze to left side head scratches on arm." Glen also had sutures in his left forearm at the time, which were removed in custody on 10 March 2015. Those sutures were not noted on the form. At the bottom of page 5 of the IIO form, towards the end of the section titled "Officers Visual Assessment – Self Harm" Correctional Officer Sylvester ticked has "no" in response to the question "[a]fter reading the Police CMR and completing this interview and visual assessment, in your opinion, is the offender at risk of self-harm or suicide?"

57. The Assistant Superintendent's evidence was that Correctional Officer Sylvester would have had access to OIMS when completing the reception process. On that system there was a current alert for Glen which stated, "history of self-harm incident". The IIO form, on page 6, required the screening officer to check the computer system, asking the question, "are there any alerts on OIMS?" in response to which Correctional Officer Sylvester ticked, "no". This was plainly incorrect.

58. In his statement Correctional Officer Sylvester indicated that he "did not enter the information from the interview on the OIMS" as "I have not been trained how to perform this function and do not have access to this function." It appears that Correctional Officer Sylvester was saying that he had not been trained to input the information on OIMS.

When taken to this statement Assistant Superintendent Kearney was somewhat surprised and thought that the officer may not have had training in how to input fresh data but he thought he would have had the knowledge and experience to use the system to look up information. He considered it inconceivable that someone with 18 years' experience (as Correctional Officer Sylvester had) wouldn't be trained at all in how to use the OIMS system.

59. AS Kearney's evidence was that the sutures should "definitely" have been recorded on the IIO, if not in answer to the question about neck and wrist scars, then in the "comments" box underneath. He thought, in circumstances where an inmate had an alert on OIMS for a previous self-harm incident, that it would have been appropriate to raise concerns about the sutures sufficient for the information to be passed down the line. He stated that the IIO is relied on by the reception centre (in this case Cessnock CC) as a guide. It was the opinion of the Assistant Superintendent that the IIO form had been poorly done.

60. The Assistant Superintendent properly conceded that there may be a motive for a new inmate not to disclose self-harm on reception, the reason being that being placed on some form of RIT at the gaol of placement was not necessarily a pleasant experience in view of the isolation, what one has to wear and the constant observation in a safe cell. The Assistant Superintendent also said that the officers he supervised had not had any sort of training in relation to risk assessment until recently, but that in July 2017 there had been some training for him and his reporting officers in relation to Immediate Support Planning for inmates with mental health issues, which was directed at suicide and self-harm prevention.

61. The conclusion I reach, not contested in submissions by Counsel for the Commissioner of Corrective Services, is that there were deficiencies in the information Correctional Officer Sylvester recorded. In particular, the documenting of possible risk of self-harm in respect of Glen was simply inadequate. Counsel for the Commissioner submitted that, notwithstanding the deficiencies in how Correctional Officer Sylvester recorded his assessment of Glen, they were somewhat ameliorated by Glen being further and properly assessed by officer Mark Hayes, Justice Health Nurse Wells and welfare officer Neville Bowen and that, as a result of their collective assessments (their evidence which I will shortly come to), there was no reasonable basis for any of those people to determine at the time each of them assessed him that Glen was at risk of suicide.

62. It is important to draw a distinction between self-harm and suicidal ideation. They are two very different issues. While it cannot be extrapolated that the above deficiencies in any way affected the outcome on 27 April 2015, the importance of the initial screening process cannot be underestimated. It provides a guide to the receiving correctional centre as to what to look for and conceivably whether to engage a RIT to further assess the inmate.

63. The Assistant Superintendent was an impressive witness and was able to provide important and helpful evidence to the inquest.

Screening by Senior Correctional Officer Hayes at Cessnock CC

64. Once Glen arrived at Cessnock CC a "Reception Checklist" assessment was carried out by Senior Correctional Officer Mark Hayes ("Senior Correctional Officer Hayes"), who was an

acting Assistant Superintendent at the time. This officer's evidence was largely uncontroversial. He gave evidence that:

A. He had performed the inmate reception/assessment task many times previously;
B. He had on-the-job training on the inmate reception/assessment task;
C. Assessing an inmate for risk of self-harm was a "there and then" assessment based on their demeanour and their state of mind;
D. He did not get records from Justice Health (who see the inmate in the police or court cells prior to his assessment) but he checked OIMS for alerts etc on the inmate he was assessing;
E. He recalled seeing a stitch that looked infected and he asked Glen to tell the nurse about it when he saw her;
F. He often sees inmates come in with wounds on their arms, and not every wound around the arm is a result of self-harm;
G. He knew Glen from prior custodial sentences and if he had found he was not in a good place he would have put him on a RIT to be followed up the next day;
H. A lot of inmates have alerts on OIMS for self-harm, but not all of those alerts are as a result of self-harm acts. Some are for self-harm threats, for example, which may be made as a result of frustration, or as a way to get something the inmate wants;
I. If he thought Glen needed a psychologist or nurse, the fact of limited psychological resources within the prison wouldn't stop him from making a referral;
J. Glen denied thoughts of self-harm and suicide at the time of the assessment and one of the questions posed on the form completed by Senior Correctional Officer Hayes was "do you have any current thoughts of self-harm/suicide?" The word "no" is circled. If the answer had been "yes", the form requires that a Mandatory Notification Form is raised which would then require a RIT assessment;
K. He considered that Glen's demeanour was no different from any other time he had seen him and did not see any cause for concern;
L. Although his recollection was poor he said he would have satisfied himself about whether the cuts on Glen's arm were from self-harm or not. He accepted that he could have provided more detail about his assessment in the comments section of the form, and said that was something he had taken away from the inquest. He said he'd had some mental health training at the Brush Farm Academy about 10 years ago, but was considering doing a further course. He also indicated that he imagined some inmates might wish to downplay self-harm thoughts to an assessing officer for the reasons that I have already expressed.

Screening by Welfare Officer Bowen at Cessnock CC

65. Glen was screened by Mr Neville Bowen on 11 March 2015. Mr Bowen is a Corrective Services welfare officer with approximately 16 years' experience in his role. Prior to Mr Bowen's intake screening interview, Glen had already been assessed by nurse Julie Wells on behalf of Justice Health who recommended "normal cell placement". Mr Bowen conducted the screening interview with Glen which took approximately 40 minutes and filled in an Intake Screening Questionnaire (ISQ).

66. Mr Bowen did not have formal mental health training. He said that he made assessments of a person based on their presentation at the time. He would consider the answers they gave and his focus was on their current thinking. For example, Mr Bowen was asked whether, given that Glen had disclosed a history of schizophrenia, it would have been a good idea to refer him to psychological services. He replied that it would depend on his presentation, such as, for example, if he reported that he was hearing voices or expressed delusional thoughts. If there was no indication of anything like that, he said he would not make a referral.

67. Mr Bowen was shown the Justice Health document titled "D&A and MH Summary of RSA for CSNSW", where Glen had been recorded as saying that he had tried to self-harm in the past. Mr Bowen said that he had "more than likely" seen that document as it should have been in Glen's case file. He said that this information wouldn't necessarily prompt him to refer Glen to a psychologist as, in effect, he would have discussed it with Glen and gauged his current thinking.

68. He accepted that question 75 of the ISQ combined the concepts of self-harm and suicide within the one question, asking, "[d]o you have any plans to self-harm or take your life?" He stated that, in his role as a welfare officer, he had met inmates who had self-harmed for the "relief" or "release" it provides, or as a "cry for help". He accepted that there would be some benefit in asking those questions separately, as he saw self-harm and suicide as being separate issues.

69. Mr Bowen did not agree with a suggestion, made by the lawyer representing Glen's family, that a physical inspection of the inmate's neck, arms, hands and face for self-harm injuries could be incorporated into the ISQ. He noted that inmates are already strip-searched when they first arrive at Cessnock. He did not consider it was his role as a welfare officer to be involved in a physical inspection and he thought it would be difficult to ask a person to disrobe.

70. Mr Bowen recorded in the ISQ, among other things, that Glen presented as "well-groomed", denied having current plans to self-harm or take his life, said he was expecting Ms Te-Wake to visit him, had a history of schizophrenia for which he took medication daily, and was not withdrawing from drugs. Mr Bowen noted the active alerts for Glen on the OIMS.

71. Mr Bowen was taken to the "Narrative Summary" section of the ISQ form, where he had written that Glen "states ok for phone contact" and indicated that the note meant that Glen had declined the offer of a telephone call. He said that Glen did not provide him with any telephone numbers for external calls. What emerged from Mr Bowen's evidence was that he considered that the reason for phone contact was for the inmate's benefit (this appears to be the same understanding Mr Raper and Mr Mumford had of the offer of a phone call and, to some extent, Ms Ceeney, as was evident from their oral evidence).

72. The phone call is in fact a component of the intake screening and its purpose is for the screener to obtain further information from a third-party that may contribute to the assessment of risk (as is set out in the relevant section of the then current Operations Procedures Manual). Mr Bowen conceded that obtaining collateral information would be important, particularly if an inmate was downplaying their state of mind.

73. Mr Bowen did not see any scars or wounds on Glen's arms during the 40 minute interview. The interview does not involve a strip search and Glen was fully clothed at the time. Mr Bowen agreed that he must have reviewed the Custody Management Record ("CMR") completed by Sergeant John McManus on 6 March 2015, however did not recall seeing pages 2 and 3, which are missing from the copy in the Corrective Services Case Management File. As already mentioned, the missing pages referred to, "large open wounds on forearm". It is unclear how the CMR came to have missing pages and I do not make any criticism of Mr Bowen in relation to this. He said that, if he had seen pages 2 and 3, "it would have been something to refer to when I asked Mr Russell about previous self-harm".

74. From Mr Bowen's observations and experience, he did not form the view that Glen was at risk of suicide on the day that he assessed him, nor did he consider that Glen was downplaying his mental health status when he was assessing him.

75. Mr Simon Raper, who held the position of acting General Manager at the time Glen was in custody, and who is currently the Governor of Cessnock CC, gave evidence that training modules, including a three-day course called "Mental Health First Aid," were available to staff. The tenor of his evidence was that staff were encouraged, but not required, to complete all training on offer, although some was mandatory. He stated that, due to the pressure that Corrective Services was under, training had "fallen off over the last number of years". He said that it was now getting better, but that it was up to individual members of staff to submit a request if they wanted to do a particular course.

76. Mr Raper conceded that he had also thought that the screening phone call was primarily intended to permit family contact and not to obtain collateral information. He accepted that obtaining collateral information would assist in undertaking the risk assessment and said that steps could be taken to train officers in the appropriate application of the policy.

77. Mr Raper said that inmates are strip searched when they first enter the correctional centre from the police or court cells, and agreed that that was the appropriate occasion for any obvious injuries to the wrist, forearm or neck to be noted. He suggested that the best way of dealing with any such injuries might be to verbally communicate them to the intake officer in charge who would be located right next door, and who would be conducting a reception interview with the inmate shortly afterwards. He said that, in contrast, the ISQ may not take place until several days later.

78. The lawyer for the family also questioned Mr Raper about the ISQ and the training of officers like Mr Bowen in mental health assessment. Mr Raper agreed such training would benefit that process. I will refer to Mr Raper and his evidence again later in this decision.

79. Ms Donna Ceeney was, at the relevant time, the Manager of Offender Services and Programs at Cessnock CC. She gave evidence agreeing that question 75 in the ISQ form could be amended to provide the two discrete questions I have referred to in paragraph 68 above. She agreed that self-harm and suicide were two very different things.

80. She agreed with Mr Bowen that the ISQ assesses the inmate's current presentation (described by Mr Bowen as a "pinpoint in time"). However she said that, hypothetically, if a welfare officer saw sutures/injuries on an inmate's forearm, and they looked suspicious, that would warrant filling in a Mandatory Notification Form even if the injury was several weeks old. It would still be regarded as relevant to the inmate's current risk.

She agreed that clarifying in the policy what is meant by the inmate's current presentation would be a good thing to do.

81. She was shown a photograph of the scars on Glen's arm and was asked whether it would concern her that a person with those scars was not identified as at risk of self-harm. She answered by saying that she would be concerned if the scars were visible to the welfare officer conducting the screening and no note of them had been made. She considered that a physical inspection by a welfare officer conducting an intake screening would be a disadvantage. She said the welfare officer is trying to build rapport and trust with the inmate in order to elicit the information necessary to complete the ISQ. She indicated that asking someone to roll up their sleeves or remove clothing could potentially damage that trust and said that she didn't agree with it at all.

82. Ms Ceeney gave evidence that once in the gaol environment it would be very difficult for Corrective Services staff, in circumstances where Glen was not actively psychotic or acting out, and was keeping to himself, to identify that his mental health may have deteriorated. She agreed that it illustrated the importance of the Intake Screening process. I note that there was no evidence to suggest that Glen was displaying obvious symptoms of deterioration in his mental state after his admission into custody at Cessnock CC such that correctional officers should have noticed and responded. According to Glen's cellmate, he was quieter than usual, but he did not notice anything alarming which would have indicated to him the need for intervention and assessment.

Screening & assessment conducted by Justice Health

Screening by Nurse Henderson at the Newcastle Police Cells

83. I now turn to the Justice Health screening and assessment. Glen's initial assessment was carried out by registered nurse Sue-Anne Henderson ("Nurse Henderson"), who undertook the Reception Screening Assessment ("RSA") in the Newcastle Police Cells on Saturday 7 March 2015.

84. Nurse Henderson observed multiple cuts and sutures on Glen's left forearm, which he told her were from putting his arm through a window, although he also disclosed having previously tried to hurt himself. She was told by Glen that he was on a medication called Mirtazapine and that he had been diagnosed with depression and schizophrenia. She identified that Dr Singh was Glen's community GP although she was not able to ascertain Dr Singh's contact details from the police cells on the weekend. As a consequence she only partly completed a form called a "Consent to Obtain Health Information from External Agencies" form which requested, among other things, written verification of Glen's prescribed medications. She said she knew the form would accompany Glen to his gaol of placement, where a further Justice Health screening would occur, and that she did not fill in Dr Singh's name in case it was assumed by the Justice Health nurse at the gaol of placement that the form had already been sent. She said she would have expected that the form would be faxed to Dr Singh early in the week following her assessment of Glen.

85. Nurse Henderson explained that, currently, the Consent to Obtain Health Information from External Agencies forms are sent to an "ROI clerk", based in Sydney, who sends the forms out to the community health provider, keeps track of whether the inmate's health information has come in and, if so, places an alert on the computer system so that Justice Health staff in the correctional centre are aware. She said that this system was

brought in because in the past the forms were not being followed up. She said that, in the early days of the ROI clerk system, there were no ROI clerks rostered on over the weekend, and she assumes that is why she did not fax the form to the ROI clerk herself, along with a note asking him or her to find out Dr Singh's contact details. Nurse Henderson said that now that is what she would do if she was unable to ascertain a community health provider's contact details herself.

86. Nurse Henderson also explained that the ROAMS protocol (ringing up an on-call doctor to have medication prescribed) would apply if the patient brought with them into custody previously prescribed and labelled medication in their name and it would also apply if the external GP had supplied information to the gaol as to the inmate's current prescribed medications.

87. As already noted, Nurse Henderson asked Glen as part of the RSA whether he had ever tried to hurt himself, to which he replied "yes". This was a mandatory question, marked by an asterisk on the electronic RSA form. When the Justice Health screener receives an answer of 'yes' in response to that question, the electronic form displays a number of follow-up questions, including, "provide details", "when was your last attempt", "how" (did you self-harm) and "why" (did you self-harm). These follow-up questions are not mandatory and Nurse Henderson did not ask them of Glen. Nurse Henderson also did not conduct a Kessler 10 survey with Glen, which is included in the electronic RSA form as an optional component of the mental health screening. The Nursing Cluster Manager, Ms Roslyn Pavey, suggested in her evidence on 26 February 2018 that, clinically, it would be a good idea to ask the Kessler 10 questions where a person reported depression and schizophrenia. Justice Health's Operational Nurse Manager Custodial Health, Ms Terri Sheehan and Ms Pavey both suggested it would make good clinical sense to obtain further information about previous self-harm.

88. Nurse Henderson was cross-examined about whether it would have been appropriate to take a conservative approach to the sutures and cuts on Glen's arm and to record them as a possible act of self-harm. She said that she would have discussed those injuries with Glen and would have taken into consideration his response, as well as his history. However she said that the focus of the RSA was on "what's happening now." She said she once had a patient who had attempted suicide 3 days prior to coming into custody and when they came into custody they were not suicidal anymore. She said that, while you take into account the history, you can't let it dominate the assessment. She said that if Glen had been expressing thoughts of self-harm or suicidal ideation when she saw him she would have put him on a RIT.

89. Nurse Henderson also explained that she does not automatically get access to court-ordered mental health assessments, as the court liaison nurses in Newcastle are employed by Hunter New England Health and their records are entirely separate from Justice Health. She also explained that collateral information from family members was not generally sought. Justice Health's Clinical Director, Primary Care, Dr Katerina Lagios said in evidence that reception nurses have a very busy job and have to go with what is in front of them. They don't have time to go back through old documents.

90. Prior to working in the Newcastle Police Cells, Nurse Henderson worked at Cessnock CC for around five years. She said that, in mental health facilities, patients are observed constantly because it is known that someone's mental health can change "literally over the hours." She agreed that, to really monitor a person's state of mind would require much more frequent mental health assessments than are possible in the correctional

environment (I understood this evidence to relate to inmates in the general prison population and not inmates who have been placed on a RIT). She agreed that, working on the model that you needed to assess how a person was at a "pinpoint in time" (there and then) and accepting that a person's mental health could change rapidly, the only way that Justice Health could assess a person more frequently than a recommended follow-up time in the Patient Administration System ("PAS") or scheduled assessment, (outside of brief medication administration encounters), was if they self-referred for help.

91. Nurse Henderson considered that if she had been assigning Glen a wait list priority level on PAS to have a mental health assessment carried out by a mental health nurse, she would have probably assigned him a priority level 3, as he was going to receive his medications and he was not presenting as unstable at that assessment. A priority level 3 meant he might not be seen for up to 3 months. I note that it was not in fact Nurse Henderson's role to make that classification, which fell to Nurse Wells at the gaol of placement.

92. Nurse Henderson described her understanding that the models of care within Justice Health have changed within the last 12 months and that an inmate's initial mental health assessment is now carried out by a suitably qualified primary health nurse at the receiving gaol and, if things arise in that assessment that warrant further attention, the inmate is then referred to a mental health nurse. The aim of this policy change is that inmates are seen and assessed faster.

93. Given that the Kessler 10 survey and follow-up questions were not mandatory, together with Glen's denial of current self-harm, it could not be concluded that the assessment conducted by Nurse Henderson was inadequate. Even if Nurse Henderson had asked the follow-up questions it is quite possible that Glen may not have been candid with her, given that he had chosen not to disclose recent self-harm to those assessing him. No criticism can be levelled at Nurse Henderson in relation to the assessment undertaken by her on the day.

94. Given the evidence of Ms Sheehan and Ms Pavey about the asking of follow-up questions (where a patient has said "yes" to previous self-harm or trying to end their life), it would be my recommendation that the RSA form be amended to make it mandatory to ask the further questions where a patient answers "yes" to either of these questions. Ms Sheehan agreed that this should occur. It would still be a matter for clinical judgement to administer the Kessler 10 survey, but practitioners ought to be encouraged to do so when a patient reports a history of, or treatment for, depression.

95. I would also encourage Justice Health to obtain expert clinical consideration as to whether the focus on an inmate's "current presentation" for mental health in the Reception Screening Assessment ought to include not simply the presentation of the patient on the day of assessment but a gathering of information from the patient relating to, say, the previous 4 weeks of the patient's life. This would be consistent with the approach taken in the Kessler 10 survey and for drug and alcohol questions.

Screening by Nurse Wells at Cessnock CC

96. Nurse Wells assessed Glen upon his arrival at Cessnock CC on Sunday, 8 March 2015. She was a primary health nurse of considerable experience, who had worked at Cessnock CC for twenty years. The paperwork provided to her from Nurse Henderson included the RSA and the part-completed "Consent to Obtain Health Information from

External Agencies" form. Ms Sheehan gave evidence that a Justice Health nurse conducting a reception assessment at the gaol of placement will review the RSA and sometimes have to "add more to it". This was also the evidence of Ms Pavey.

97. Nurse Wells gave evidence on 2 occasions. On the first occasion she provided evidence while on holidays overseas and it was by telephone. It became quickly apparent that she had not taken the opportunity to refresh her memory from any material and it appeared that she may not have even had her statement with her. She said she had made her statement "off the top of her head" without the assistance of records. She repeated that assertion in oral evidence on the second occasion, on 26 February 2018. She said that she had resigned from Cessnock CC because she was tired of being understaffed and under pressure.

98. On both occasions that she gave evidence she said that she had spoken with Glen for about an hour to conduct her assessment on 8 March 2015. The written documentation generated during the assessment consists of a short progress note, a PAS waiting list entry for a mental health assessment, a Health Problem Notification form and the document titled, "D&A and MH Summary of RSA for CSNSW". The D&A and MH Summary of RSA form has a time of 14.39 on it, and the progress note has the time 15.30 on it so that does in one sense support her evidence. However the actual records generated by her during the assessment lack detail and appear cursory. In cross examination, when it was suggested that she had spent less than an hour, she said, "I can't recall, I really can't" but on the second occasion in her evidence maintained her original position. My assessment of her evidence on the first occasion was that it was unreliable – perhaps not helped by being over the telephone.

99. My assessment of Nurse Wells' reliability on the second occasion that she gave evidence was that she appeared to be too quick to give answers that she really hadn't thought through and again was unreliable. For example, she maintained in oral evidence on 26 February 2018 that she had asked the Kessler 10 questions. Her evidence was that she either wrote the answers on a piece of paper (which does not appear in the records) or she was called away before having a chance to save the amended RSA. Later she said that she had no specific recollection of asking the questions, but it was her normal practice to do so. On balance, I do not believe she asked the Kessler 10 questions.

100. Nurse Wells told the inquest that she did not inspect Glen's arm as it was bandaged and she did not want to "aggravate" the injury. She recorded in the progress notes the reason for his injury as, "cut himself when high on a pill." She also documented in the progress notes that he denied any thoughts of self- harm.

101. In filling out the Health Problem Notification form, she left the section titled "signs/symptoms to look for in the inmate" blank. The purpose of that form, as I understand it, is for Justice Health staff, following their assessment of the inmate, to put Corrective Services staff on notice of signs or symptoms of any health problems suffered by the inmate. That way, if those signs or symptoms arise, Corrective Services staff can report them to Justice Health staff, who can address them. Nurse Wells said on 28 August 2017 that she didn't feel she needed to include any information in that section because, although Glen had a mental health history, he wasn't "presenting with it... he wasn't showing any mental health problems or any thoughts of self-harm." On 26 February 2018 she acknowledged that thoughts of self-harm can come and go and that a patient who is in a particular mindset on a given day may be in a completely

different mindset a few days later. She agreed that it was a mistake not to refer to Glen's history of depression and self-harm on the form.

102. On 28 August 2017, Nurse Wells did not accept that she had assigned Glen a waiting list priority level of 5 on the PAS. She said she didn't remember what the categories were. She said Glen probably shouldn't have received a referral for mental health at all, even with a history of self-harm and having reported depression and schizophrenia, "unless he was presenting with any of the symptoms or actually asked to see the mental health nurse". On 26 February 2018, Nurse Wells said that she now accepted she had created the waiting list priority level of 5 in PAS and that, based on what she now knows (and taking into account what happened to Glen on 27 April 2015), Glen should have been allocated a priority level of 2. Importantly, she said that she had not been aware that priority level 5 was reserved for patients who had already had a mental health assessment and who required follow-up.

103. Nurse Wells acknowledged that she would have received Nurse Henderson's part-completed Consent to Obtain Health Information from External Agencies form on 8 March 2015. She could not explain why she did not put Dr Singh's name on it. She said she had put the form on the Cessnock CC clerk's desk so that he or she could send it to the ROI clerk in Sydney the following day (it being a Sunday). She accepted, however, that the clerk would not have known who Glen's GP was, unless it was included on the form or one of the nurses asked Glen for that information.

104. Overall, little weight can be attached to Nurse Wells' recollection, particularly to her assertion that she completed a Kessler 10 survey. However I note that Dr Katerina Lagios said in her evidence that the Kessler 10 survey was used to check someone who was acutely unwell and there was no evidence in the inquest that Glen was acutely unwell at the time of his presentation to either Nurse Henderson or Nurse Wells.

105. The categorisation of Glen as a priority level 5 on the mental health waitlist, having reported a history of depression and schizophrenia, was entirely inappropriate and the strong inference I draw is that Nurse Wells' assessment of Glen on 8 March 2015 was a more cursory assessment than that which she recollected performing.

Evidence of Mr Mumford

106. Mr Mumford, who was the General Manager of Cessnock CC at the time (but on leave as at Glen's death), agreed that reviewing the reception and screening tools was a good thing to do, particularly as the modern prisoner profile is changing and evolving.

Wait List Priority Levels in PAS for Mental Health Assessment

107. The assignment of a mental health assessment Wait List Priority Level on PAS was a recurring issue that arose in evidence at the inquest.

108. Evidence as to the correct approach to the PAS waiting list priority levels was provided by Ms Terri Sheehan, the Operational Nurse Manager Custodial Health, on behalf of Justice Health. She indicated that: –

A. Priority Level 1 was for "patients whose health condition may deteriorate and require attention within 1 – 3 days".

B. Priority Level 2 was for "patients where lack of intervention may result in an adverse outcome and requires attention within 3 – 14 days".
C. Priority Level 3 was for "patients who are stable but will require attention within 14 days to 3 months"
D. Priority Level 4 was for "patients who are stable but require a review within 12 months".
E. Priority Level 5 was for "patients needing follow-up but within no specified time".

109. The above explanation covers all categories of patients, not just mental health patients.

110. The evidence heard at the inquest suggested that there was a wide range of approaches to the categorisation of a patient being wait-listed for a mental health assessment. Ms Sheehan said that Glen, as a new admission, could probably have been waitlisted as a priority level 1 or priority level 2, due to his reporting of a history of depression and schizophrenia. In oral evidence, she said that if there was evidence of a recent self-harm episode (or of what appeared to be a recent self-harm episode), then she would have assigned Glen a priority level 1 or a priority level 2.

111. Ms Robyn Lloyd, the Nurse Unit Manager at Cessnock CC, indicated that, in her view, a priority level 3 would have been appropriate for Glen, as he did not report suicidal ideation, was apparently stable on his medications in the community, and was presenting as calm, co-operative and not withdrawing from any substances that could have been affecting the assessment. She said, however, that if she had known that the lacerations to his body were self-harm, she would have assigned him a Priority Level 2.

112. Nurse Henderson said that she would have probably assigned Glen a priority level 3, taking into account his current stable presentation, his admission to having tried to hurt himself in the past, and her belief that he would have access to his medications (but she appears to have accepted his advice on face value that he had not self -harmed so far as the cuts on his arm were concerned). Nurse Henderson appeared to place particular emphasis on the presentation of Glen at the time of the assessment.

113. Ms Rhonda Sharpe, who was the only mental health nurse for the maximum security section of Cessnock CC in 2015, described in her statement her understanding of the operation of the priority levels in a mental health context as follows: priority level 1 was high risk, most commonly suicidal ideation and/or attempt, and/or threatening harm to self or others; priority level 2 was suicidal ideation with no actual attempt/unstable. In her oral evidence she clarified this by stating that an inmate would be a priority level 1 if he had actually been self-harming or priority level 2 if he had only been threatening self-harm. She explained her reasoning with the illustration that if a person was actually self-harming, not intending to suicide, they may however accidentally cut an artery and die. In submissions it was conceded by counsel for Justice Health that assigning Glen a PAS priority level of 5 on the mental health nurse waitlist was incorrect in the circumstances. However Justice Health does not concede that this categorisation was a material cause of Glen's death on 27 April 2015.

Workload and Staffing Arrangements for Justice Health Nurses

114. A further issue arose during the course of the inquest. That issue concerned the workload and staffing arrangements for Justice Health nurses and an alleged instruction not to assign patients waitlist priority levels 1 or 2 in PAS. This evidence was given by

registered nurse Kate Quarello ("Nurse Quarello"). She said that she had been instructed at Cessnock CC not to assign anyone a higher priority level than 3, because there was difficulty seeing people allocated a priority level 1 or 2 within the requisite timeframes. The instruction was, she thought, contained in an email from the cluster manager (Ms Roslyn Pavey) and the nursing unit manager (Ms Robyn Lloyd) had reiterated it. She recalled that the mental health nurse (Ms Rhonda Sharpe) had also mentioned it. Nurse Quarello also thought she may have been copied into an email containing the instruction. She said that the instruction was in place when she first commenced at Cessnock CC in February 2015.

115. During the adjournment period (i.e. from August 2017 to February 2018) a thorough search was made by senior officers of Justice Health of emails sent by Ms Pavey, sent and received by Nursing Unit Manager Lloyd, and received by Nurse Quarello, during the relevant period. No email was located that suggested this instruction. There was located at an earlier time discussion concerning inappropriate categorisation of patients for the GP and it is possible that Nurse Quarello may have mistaken that as a directive not to use priority levels 1 and 2, however it could not be cleared up with Nurse Quarello as she had already been excused and was not recalled. Ms Pavey and Ms Lloyd denied issuing any such instruction or being aware of any such instruction.

116. Nurse Quarello said that the Justice Health nurses were responsible for around 300 inmates in the maximum security section of Cessnock CC. She said that pretty much every shift they were short-staffed. She said there was one mental health nurse and a drug and alcohol or sexual health nurse who would rotate roles. She said that, in respect of primary health nurses, a "well-padded" shift would have 4 primary health nurses (two doing medications, two doing clinics). She said that, as a registered nurse, if you were rostered on with an "EN" (enrolled nurse) it was "an incredible amount of pressure" because there are a lot of tasks the EN cannot perform, including obtaining phone orders and conducting RSAs. There were medications the ENs could not administer.

117. Nursing Unit Manager Robyn Lloyd agreed in cross-examination that all RSAs were conducted by the evening staff and when an Enrolled Nurse was rostered on the evening shift, those nurses were not authorised at that time to conduct an RSA. Ms Robertson, appearing on behalf of Nurses Wells, Henderson and Quarello, has submitted that this resulted in placing more pressure on the registered nurse(s) working the evening shift.

118. Ms Lloyd also conceded that the staffing at Cessnock maximum was "less than ideal" in terms of actual resourcing at times (that is, staff who were actually available on a given day to staff the positions) and the system was "under pressure". Ms Robertson submitted in written submissions that the rosters, in particular the sign on sheets, between February – May 2015 indicate the following:

- On 27 occasions there were fewer than 3 nurses signed on for the morning shift; and
- On 22 occasions the skill mix on the morning shift included a registered nurse with 2 Enrolled Nurses or a Registered Nurse with an Enrolled Nurse and a new staff member or new graduate nurse.
- On 37 occasions a Registered Nurse was rostered on the evening shift with an Enrolled Nurse.

(The above submission was not challenged, and on that basis its accuracy is assumed for the purposes of these findings).

119. Nurse Wells, when she gave evidence in February 2018, said she recalled a morning shift when an Enrolled Nurse was rostered on alone. The rosters clearly show that an Enrolled Nurse was rostered alone as the primary care nurse on the evening shift of 25 February 2015 and the morning shifts of 6 February 2015 and 10 April 2015.

120. Nurse Gebhard-Long completed her nursing qualifications in 2014 and commenced employment at Cessnock Maximum Correctional Centre on 9 March 2015 in the new graduate program. Following orientation, she first appears on the roster on 23 March 2015 as a supernumerary working with Nurse Wells and an enrolled nurse on the evening shift. On 24 March 2015 she was rostered on the evening shift as supernumerary with Nurse Quarello and an enrolled nurse who was working 6 hours. On 25 March 2015 she was rostered on the evening shift as supernumerary with Nurse Wells and Nurse Quarello.

121. Nurse Gillies completed her nursing qualifications in 2013 and commenced employment at Cessnock maximum in April 2015 and worked for approximately 6 months before resigning. Nurse Gillies was not called to give evidence in these proceedings. She first appears on the roster on 20 April 2015 on a morning shift with Nurse Wells, an Enrolled Nurse, a new Registered Nurse and Nurse Quarello. On 23 April 2015 she was rostered with Nurse Gebhard-Long on the morning shift. On 27 April 2015 she was rostered with Nurse Wells on the evening shift. On 4 May 2015 she was rostered on the morning shift with an enrolled nurse, student nurse and a new staff member/casual registered nurse.

122. Dr Katerina Lagios, in her evidence, acknowledged that there was a problem attracting staff to a local area like Cessnock; it was common ground that there had been no qualified mental health nurse there since Nurse Sharpe left in April 2016, despite multiple attempts to recruit new staff. The current occupant of the position was undergoing the appropriate training and education.

123. Assuming these quoted statistics to be reliably extracted, it is apparent from them in my view that Justice Health nurse staffing levels at Cessnock CC were and possibly to this day are still, vulnerable, particularly when people are absent or otherwise on leave at any given time. Certainly between February and May 2015 they were less than adequate.

Failure to commence Glen on his medications in a timely manner

124. When Glen was assessed by Nurse Henderson on 7 March 2015 he told her that he was taking Mirtazapine in the community, however the Justice Health records show that he was not re-commenced on Mirtazapine until 2 April 2015.

125. With respect to the failure to commence Glen on his medication once he was in custody in a timely manner, the evidence was not contested - the Consent to Obtain Health Information from External Agencies form was part-completed on 7 March 2015; it should have been processed on 9 March 2015 (or shortly thereafter) by a clerk but it did not have Dr Singh's name on it, due to a failure to add that information to the form once Glen was transferred to Cessnock CC. A fresh form was completed on 23 March 2015 by Nurse Quarello, then, inexplicably it was not sent off for a further week, by a person unknown who purported to be Nurse Quarello.

126. Evidence was received that there is a new system in place, with the ROI Clerk available 7 days per week. However that new system will still depend on appropriate compliance by staff, including filling in the form adequately.

127. The inquest was greatly benefited by Dr Christopher Ryan's careful analysis of Glen's medical records. On his evidence, it would appear that Glen was unlikely to have suffered from major depression (although he was unable to exclude this as a possibility). He was comfortably satisfied that Glen did not suffer from schizophrenia. So far as the delay in re-starting Glen on appropriate medications was concerned, Dr Ryan concluded that there would have been neither therapeutic benefit in recommencing the drugs nor any harm. Had there been any relapse into major depression, it is likely that it would have been addressed, or substantially addressed, by the recommencement of mirtazapine on 2 April 2015. Accordingly, it appears likely that not being medicated for some three and a half weeks did not play any significant part in Glen's decision to take his own life on 27 April 2015.

How Corrective Services and Justice Health monitor the well-being of inmates and to what extent is engagement by an inmate with the various services on offer a voluntary process

128. Mr David Mumford was the general manager of the Cessnock Correctional Complex in April 2015, however at the time he was on extended sick leave. He has over 30 years' experience working for Corrective Services. He was questioned about a Health Problem Notification Form dated 18 December 2014 (from one of Glen's previous periods in custody), completed by Nurse Henderson, which listed the following signs and symptoms for Corrective Services officers to look out for: "inappropriate talking, laughing, moody, agitated, change of self-care, isolative or over-familiar behaviour". Nurse Henderson's evidence was that this was a form of words she used on Health Problem Notification Forms for all inmates with a history of mental health issues, and that it came from a Justice Health document which provided guidance to nurses filling out those kinds of forms. Mr Mumford said that, unless there had actually been an agreement between Justice Health and Corrective Services as to what that particular form of words related to, this was a "very subjective document" (I note that there was no evidence before the inquest of such an agreement).

129. Mr Mumford was asked, in particular, about what a correctional officer would be looking for if they were asked to look for "isolative behaviour" on a Health Problem Notification Form. He replied that it would be "incredibly difficult" to work that out. He said that there are practical reasons that inmates might seek to isolate themselves, such as, to keep away from the gang culture in the gaol. He said, "[t]hat doesn't mean they're at risk of self-harm, it means they just want to do their own gaol...it's their way of surviving in a correctional centre". He did however make the obvious observation that if a correctional officer observed someone appearing mentally unwell they should report it.

130. Mr Mumford agreed with the proposition that, if an inmate was psychotic or acting out, then that would be easier for correctional officers to detect than if someone was withdrawing into their shell. He said that correctional officers have more contact with inmates on a daily basis than Justice Health nurses and that the process, if an inmate wants to see a Justice Health staff member, is to complete a self-referral note and take it to the "post box" or to contact a correctional officer and ask to go to the clinic. Justice Health nurses come in to dispense medications but there is no routine nursing triage each day.

131. Counsel Assisting asked whether Mr Mumford thought the following unusual: an inmate with no phone calls or visits, receiving limited correspondence, and with no case notes on

the OIMS system despite having been in custody for some weeks. Mr Mumford said that he did not think that was unusual. He said that, from what he had read in the custody record, Glen was, "quite a good inmate, wasn't a particular problem...someone like that knew how to do their gaol and...was just doing it quietly...he was a decent sort of young man, he wasn't somebody that was in people's faces, getting into trouble and involved in underhanded stuff within the centre...So, he wouldn't have been flagged at all other than by the methods that we've already discussed through screening."

132. Mr Mumford gave evidence that a mental health first aid course had been made available to staff at Cessnock CC and that quite a few did the course in 2013 and 2014. He said it was run to train staff in identifying and assisting inmates with mental health issues because more safe cells were being created. He said at any given time there will be a number of RITs being undertaken and that correctional officers' form part of the RIT process.

133. Mr Mumford was asked about the telephone call Ms Fielder-Gill made to Cessnock Correctional Centre, advising that Glen was "not in a good state". He said that it more likely than not would have been picked up by reception and that, while receptionists and telephone switch operators can view the OIMS system, they are not able to make case notes in that system and so could not have passed the information on that way. He said that the information provided by Ms Fielder-Gill should have been relayed to the duty manager who would, in the ordinary course of things, have sought Justice Health appraisal of Glen. He agreed that the information should have been passed on, recorded and acted upon "without a shadow of a doubt". There are no OIMS case notes or Justice Health progress notes recording either the fact of this telephone conversation or any action taken in response to it.

134. I agree with the comments made by Counsel Assisting that this was a failing of potential significance. It was collateral information that Glen was not in a good way, and Ms Fielder-Gill believes she may even have gone as far as informing the correctional centre that Glen had been self-harming. Either way, the information could have been used to direct attention to the need for further assessment of Glen. It is my strong recommendation that attention be given to this omission as part of any ongoing revision of the Operations Procedures Manual to the extent that procedures for handling the recording and dissemination of collateral information about an inmate are being developed.

135. Assistant Superintendent Vanessa White was, at the relevant time, the "wing officer" or officer in charge of G Block, the accommodation area in which Glen was housed. Ms White's evidence was limited in that she had only generalised contact with the inmates in G Block. She handed out mail to the inmates and they could approach her with any enquiries or concerns and come to her for referrals – for example, to the psychologist or to a nurse. In her role, she had about 120 inmates who could approach her at any given time.

136. Her evidence was that it was not unusual for an inmate to not make phone calls or have visitors, as some inmates are ashamed and don't want contact with their family. She did not consider that inmates who withdraw from others are necessarily more at risk than the average inmate. She said some inmates just want to do their time and want their custody to be quiet. In her opinion there was nothing to suggest that that type of inmate was more at risk.

137. From Assistant Superintendent White's observations, Glen didn't isolate himself all of the time – he did get out and mix with others on occasion. She said that, generally speaking, if someone was behaving oddly she would talk with them first to better understand what was happening and she would go to the clinic and speak with Justice Health if needed. Entries on the OIMS system would be made if there was a request to see welfare or the psychologist (for example). Overall, the tenor of her evidence was that she did not consider it unusual for inmates to keep to themselves.

138. Assistant Superintendent White was asked about Nurse Henderson's Health Problem Notification Form, which referred to "inappropriate talking, laughing, moody, agitated, change of self-care, isolative or over-familiar behaviour". She said she had seen that form of words "many times". She said, where Corrective Services officers received a form like that, they would look out for things like "isolative behaviour" where they could. However she also said that, from the perspective of a wing officer, when you have 120 inmates under your care and each inmate has a form specifying what to watch out for, it is an enormous task. She agreed that correctional officers are not trained nurses or doctors or mental health experts. She said that, if she did become concerned about the mental health of an inmate, she would have a conversation with the inmate away from others "so that they feel more comfortable in divulging information" and assess whether there may be a risk. She would then refer them onto the Justice Health clinic as a first port of call "if there was no psychologist or psychiatrist available".

The adequacy of the response by Corrective Services officers to the disclosure by inmate Baglee that Glen was deceased, including compliance with death in custody procedures, compliance with crime scene management and compliance with any 911 tool policy.

139. The Offender Management and Operations Deputy Commissioner's Memorandum No: 2012/01, dated 3 January 2012, contained the following direction:

> "It has been brought to my attention that the first responding officers to a number of recent deaths in custody were not carrying a 911 Rescue Tool...I am concerned that staff failure or inability to locate a 911 Rescue Tool may become a contributing factor to the death of an inmate. Accordingly, General Managers and Managers of Security are required to reinforce with all staff the importance of, and requirement to wear the **911 Rescue Tool**.
>
> General Managers and Managers of Security must also ensure that:
>
> 1. The 911 Recue Tool is worn by:
>
> ...
>
> The Night Senior and ALL other correctional officers on C and B Watches
>
> ..."

140. The Operations Procedures Manual, as it stood on 27 April 2015, set out a number of procedures with respect to crime scene management. They included instruction on the prevention of contamination of evidence, to prevent unwanted transfer of material from another source to the physical evidence; instruction on completion of a crime scene log (including detailing any activities that may have altered the crime scene from its original state and items taken from the crime scene); instruction on removing items from a crime scene and compilation of an exhibit book; first responding officer's duties; preventing

entry to the crime scene; and supervising witnesses to ensure they do not communicate with anyone.

141. Deficits in crime scene management were first identified by the Corrective Services investigator shortly after Glen's death. Mr Simon Raper, the Governor of Cessnock Maximum Security Correctional Centre, gave evidence and acknowledged that there were deficits, particularly in allowing Inmate Baglee to take items from the scene and wander around unsupervised as is clearly depicted in the CCTV footage. Mr Raper wasn't aware of whether a feedback session had taken place to discuss these deficits with the officers involved and he agreed that should take place.

142. Mr Raper also agreed that scenario–based training (in responding to a potential death in custody and in crime-scene management) is the best form of training, but said it is logistically difficult to implement as Corrective Services is under pressure to ensure that inmates are out of their cells for longer periods of time and to put scenario-based training on would ordinarily involve putting the gaol into lockdown. He gave evidence that there are times when centre-wide training is conducted in responding to fires and riots so, potentially, it would be possible to include it at that time.

Evidence of Correctional Officer Bender

143. At the time of the incident, Correctional Officer Bender was a casual correctional officer, having been in the job only 6 months (with 2 months of that being in training). Correctional Officer Bender remains employed with Corrective Services and is now a Senior Correctional Officer. Prior to Correctional Officer Bender being called, the inquest was shown CCTV footage of what occurred outside cell 15 of G 3 Pod in response to Inmate Baglee's use of the cell alarm on 27 April 2015. Correctional Officer Bender, along with other Corrective Services officers, was asked questions about the footage.

144. Correctional Officer Bender, accompanied by Correctional Officer Redfern, returned Inmate Baglee to cell 15 after his court appearance. Some minutes later, he was one of the two first responding officers to the cell alarm, along with Correctional Officer Redfern. He gave evidence that he looked through the cell door window and could see Inmate Baglee standing there yelling and Glen lying face down on the bed. He was not sure whether to believe Inmate Baglee (that his cellmate had "done himself in") or whether it might be a set up. He could not see anything obviously wrong with Glen through the cell door window and he was not sure whether he might jump up or might have been waiting for them to open the cell door. He said he and Correctional Officer Redfern were waiting for officer assistance and also Justice Health assistance in case Inmate Baglee was telling the truth about Glen. He understood his role, as a responding officer, was to render first aid if it was safe to do so.

145. The cell door was not opened for around two more minutes until two more correctional officers (Correctional Officer Neal and Assistant Superintendent Jedrzejczyk) arrived. Correctional Officer Bender said that when the cell door was opened, rather than being instructed to render first aid to Glen, he was instructed by Correctional Officer Redfern to start a time log (she being the more senior officer). He could not really remember Inmate Baglee returning to the cell (to obtain his bedding) after he initially left it. He was not aware of the existence of the suicide note until after the police came. He cannot remember writing any of the time log, but he remembers that he was nervous.

146. Having watched the CCTV footage at the inquest he agreed that Inmate Baglee, once let out of the cell, was allowed to stay in the common area and appeared to be talking to other inmates through their cell doors.

147. Council Assisting asked Correctional Officer Bender about his understanding of the policy around entering a cell in an apparent emergency situation. The thrust of Correctional Officer Bender's evidence on this point was that, where there is a tension between rendering first aid as soon as possible and safety, it is always safety (of the officers) first. Correctional Officer Bender agreed that he and Correctional Officer Redfern had escorted Inmate Baglee to his cell only minutes before without requiring the assistance of a third officer. He said that he was concerned about safety when he responded to the cell alarm because of the agitated (and perhaps aggressive) behaviour of Inmate Baglee. His observation was that he saw him pacing, and heard him yelling and screaming although he could not remember any exact words. He said, with hindsight, and having watched the CCTV footage, he thought it would have been safe to enter the cell after Inmate Baglee walked out of the cell and into the common area. He said, with hindsight, that he should have entered the cell and checked on Glen at that point.

148. In his statement dated 11 August 2016 Correctional Officer Bender said he was not carrying a 911 tool when he responded to the cell alarm because he had not been issued a 911 tool and was not aware he was required to carry one. He said he did not know where the 911 tools were located in G Block and had not been trained in how to use a 911 tool. In his oral evidence he repeated that he did not know at the time about any requirement for officers on the C Watch to carry a 911 tool. He said he currently works on C Watch and now all officers wear 911 tools.

149. Correctional Officer Bender received from the Professional Standards Committee a warning letter dated 22 December 2015. He didn't now recall the details of that letter but said he had taken on board its recommendations since then and had "learned his lesson". He agreed that scenario-based training would be helpful in learning how to handle these types of emergencies.

Evidence of Correctional Officer Redfern

150. Correctional Officer Redfern, a correctional officer for 8 years, gave evidence that Inmate Baglee was yelling at her and was very agitated when she first arrived at the cell. She could also remember that other inmates were yelling out. She could not recall the order of who went in and out of the cell once the door was opened.

151. Correctional Officer Redfern said she was shocked at the time, did not know what had happened in the cell, could see that Inmate Baglee was agitated and thought he could have been responsible for what had happened. She just did not know. She said she had a lot of thoughts going through her head. She thinks that she instructed Correctional Officer Bender to keep a time log before the cell was opened, while they were waiting for a third officer to arrive.

152. She gave evidence that she waited for a third officer because of Inmate Baglee's agitation. Looking back, she wasn't sure whether she had been trying to observe a policy or whether she was just thinking about the practical reality of the situation. She said she knew she needed to have the cell door opened, but she also needed to make sure that it wasn't a set-up. She said she did not feel she knew the inmates in cell 15 very well. She

was also thinking about the need to render assistance to Glen once it was safe. She could see Glen lying there, and spots of blood on the floor. She gave evidence that she had received training about 8 years ago at the Academy on first responding officers' duties, which involved face to face instruction by a senior officer, and she thought there may have been some role-playing training for a possible death in custody scenario.

153. She recalled seeing Inmate Baglee leave the cell with a cup and said it did not occur to her to ask him to return it. She said if faced with that situation today, she would have asked him to return the cup and would have recorded it in the time log. She was not aware that Correctional Officer Neal had removed a note from the cell until sometime later. She did not think of needing to contain Inmate Baglee once he had exited the cell. She did not remember the bedding being taken out of the cell by inmate Baglee. She handed over supervision of the scene to Assistant Superintendent Jedrzejczyk when she arrived, as she was more senior than her, however did not recall any verbal or formal handover as such. Her evidence was that she told Inmate Baglee he could not go back into the cell but Assistant Superintendent Jedrzejczyk had said it was okay. Correctional Officer Redfern said she did not think it was the right thing to do, as it risked contaminating items in the cell.

154. Correctional Officer Redfern was not carrying a 911 tool on the evening of 27 April 2015 as she wrongly thought she was not required to carry one. She gave evidence that there was one in the wing office, a 15 metre walk from cell 15. She stated that now all officers wear a 911 tool when on shift.

155. When questioned about the policy of entering a cell at night, in maximum security, she gave evidence that she understood the policy to be that there should be 3 officers in attendance before the door is opened. She said she usually tries to comply with policy but that on occasion you may need to make a judgement call.

156. Correctional Officer Redfern said that, when she first looked into the cell, she did not immediately form the view that Glen had hanged himself. She had not had any previous experience of an inmate hanging him or herself on a bed and so she was not able to tell, (independently of what Inmate Baglee was reporting) whether Glen's life was in fact in danger. All she could see was that he was lying face-down on the bed. She said she was aware that it was a possibility that Glen was injured or deceased but said that she could not tell for sure. She said she had not been de-briefed by anyone at Corrective Services in relation to this incident or her response to it.

157. Correctional Officer Redfern agreed that scenario–based training would be of assistance, but said logistically it would require a lockdown. She recalled scenario-based training (which was not directed specifically to managing a death in custody) occurring at Wellington Correctional Centre when she was there and to do the training they had to lockdown 600 inmates.

Evidence of Correctional Officer Neal

158. Correctional Officer Stephen Neal gave evidence that he had been employed as an officer of Corrective Services since the 1980s, receiving basic training in 1985. He said that, on the night in question, he was not conscious of Inmate Baglee coming out of his cell, as he was focussed on trying to see what was inside the cell. He said he saw Glen lying face-down on the bed and noticed there was something white around his neck. There was a drawer inside the wing office that had a 911 tool in it, so he went to the

wing office and retrieved it. He said he now has his own 911 tool as do all officers on B and C watch.

159. When Correctional Officer Neal entered the cell, he saw a razor near Glen's waist, some blood and a note near his neck. He said he picked up the note (with gloves on) as he had knocked it off the bed when he was trying to get to Glen's neck to cut the ligature. He placed the note in his pocket, then cut through the ligature. He said he put the note in his pocket to preserve it as evidence rather than leaving it on the floor. He took it outside the cell to see what it was and said he did not return it to the cell due to the possibility of cross-contamination. He conceded during cross-examination that placing the letter into his pocket risked contamination, and said that was not in his mind at the time of responding to the incident. He said that, in his thirty years with Corrective Services, he has been involved in an incident with a crime scene on only two occasions. He agreed that scenario-based training would assist officers to prepare for emergencies such as this.

160. Correctional Officer Neal said, with respect to entering the cell, that he had no concerns for his safety once three officers were present. He also said that, if he had been the officer who had responded to the cell alarm with Correctional Officer Bender or Redfern, he would not have waited for a third officer before entering the cell. However he said he had known Inmate Baglee for many years and knew him to be cranky, but not violent. He agreed that his prior knowledge of Inmate Baglee would have allowed him to assess the situation differently from someone more junior.

Evidence of Assistant Superintendent Jedrzejczyk

161. Assistant Superintendent Jedrzejczyk gave evidence that she had been a first responding officer at a death in custody at Long Bay Correctional Centre sometime between 2002 and 2005.

162. When she arrived at cell 15 on 27 April 2015, the Justice Health nurses were already in the cell and the area as she remembered it was quiet. Correctional Officers Bender and Redfern were also present. She accepted now that she would have been the officer in charge of the scene by reason of her seniority and rank, however she said that, at the time, she "probably" didn't think she was responsible for crime scene management as there were already people there "doing what they needed to do". She remembered Correctional Officer Redfern informing her about what had happened when she arrived and she remembered that Correctional Officer Bender was keeping a time log.

163. She remembered that Inmate Baglee was agitated, walking backwards and forwards and agreed, in hindsight, that he should not have been walking around unattended. She said she did not actually see Inmate Baglee take his bedding out of the cell as she was walking out of the pod at the time and she accepted that it should not have happened. She did not recall telling Inmate Baglee that it was alright for him to go back into the cell.

164. When asked how many officers she considered needed to be present in order to enter the cell, it was Assistant Superintendent Jedrzejczyk's opinion that there should be 3 officers. She said when she is the Night Senior and goes around checking cells she always has at least two other officers with her. She was asked about the apparent contradiction inherent in Inmate Baglee having 2 officers escort him back to the cell after his appearance at the Local Court and then apparently needing three officers to open the

cell a short time later. She said that Inmate Baglee would have been assessed on his return from court, so the officers would have felt more comfortable opening the door of the cell at that point. She conceded, however, that Glen had not been assessed and so it would not have been clear at the time Inmate Baglee was returned to the cell whether Glen posed any risk to the correctional officers.

165. While there is a conflict between the evidence of Assistant Superintendent Jedrzejczyk and Correctional Officer Redfern as to Inmate Baglee being allowed to take bedding from his cell, I do not consider that anything turns on it. I found both officers to be credible and there being some differences in evidence more likely than not arises from the effluxion of time between the event occurring and the giving of evidence at the Inquest.

Evidence of Mr Mumford

166. When asked about scenario-based training for responding to a potential death in custody, rather than relying on the individual officer's knowledge of the Operations Procedures Manual, Mr Mumford said that, having sat and listened to the hearing of this inquest, he and Mr Raper would go back and develop an on-site training component in crime-scene management and the duties of the first responding officer.

Evidence of Mr Raper

167. Mr Simon Raper, the Governor of Cessnock Correctional Centre, said that correctional officers are not robots and they need to make judgements on the spot and during the heat of the moment (such as whether to open a cell door). He said that different prison officers will make different decisions. He said that, in his view, the safety of the staff is paramount. He said that, having watched the CCTV footage of the response to the cell alarm, he did not make any criticism of the officers involved in the incident (despite acknowledging that the response may not have been compliant with the Operations Procedures Manual in all respects). He said that an "after action review" with the involved correctional officers should take place to provide feedback as to what could have been done better.

168. He gave evidence that there was an Emergency Response Group course available for staff to apply for, which takes you through "a lot of serious incidents and training on how to respond to those, duties of the first responding officer and risk priorities." He agreed that scenario-based training is best but logistically very difficult to do.

<u>Whether there is any conflict between Corrective Services safety policies concerning entry by officers into an occupied cell and the Corrective Services policy requiring an urgent response to suspected hanging or life endangering incidents.</u>

169. The Corrective Services investigator found that clarification was needed regarding the policy with respect to the opening of cell doors when responding to a cell alarm on B and C Watch in maximum security centres, where it is suspected that an inmate is hanging or his or her life is believed to be in danger.

170.

171. As noted by the Corrective Services investigator, the section dealing with maximum security centres does not specify whether the emergency procedures in section 13.2 of the OPM take precedence over the procedure for responding to a cell alarm, in circumstances where an inmate is found hanging or the correctional officer otherwise believes the inmate's life to be in danger. Section 13.2, although it emphasises that staff should make sure it is safe before entering a scene to render assistance, does not specify that any particular number of officers must be present before doing so. Further, where an inmate is found "hanging, choking or strangling" it provides that the first responding officer must render assistance regardless of whether another officer is available to assist.

172. As at 27 April 2015, section 13.2 stated that:

"**Section 13.2 Deaths in Custody**
13.2.1.1 The First Responding Officer

Upon discovering a death in custody, the FRO will:

1. Determine and assess the situation

The FRO must immediately assess the situation for any potential risks or hazards and if necessary, take action to control or minimise them. For example...call for additional staff to assist.

Prior to entering a scene to provide assistance, the FRO and all subsequent staff must make sure it is safe to do so. If responding to a cell area, ensure cell door is on-the-bolt. Protecting people and providing the injured with first aid and medical care is the first priority.

2. Establish and notify communications

The FRO...will immediately call for assistance from other officers via radio...It is the responsibility of all staff to provide first aid to injured people if in a position to do so and provided it can be administered safely. It is imperative that this is done as soon as possible to protect life.

Once the FRO has determined it is safe to enter the scene, the FRO must immediately check for signs of life and commence resuscitation (refer part 2(a) below). If the inmate has attempted to take their own life by hanging/choking/strangulation, then the FRO must take immediate steps to remove the means used by the inmate to

hang/choke/strangle themselves so that resuscitation attempts can commence (refer part 2(b) below).

The FRO must ensure Justice Health personnel are summoned to attend as soon as possible...

2(a). Check for signs of life and commence resuscitation immediately

The absence of signs of life in a person does not necessarily mean that a person has died. It may just mean that the body is functioning at a very low level and medical instruments are necessary to detect such signs...If the inmate is not breathing or a heart beat cannot be detected resuscitation attempts must be started...Resuscitation attempts must continue until medical personnel arrive and take over...

2(b). Immediate response to a hanging

Hanging is one of the most common forms of suicide amongst inmates. If an inmate is found hanging, choking or strangling, the FRO must attempt to remove whatever is causing the inmate to hang, choke or strangle. This must be done regardless of whether or not another officer is available to assist..."

173. Although some minor revisions have been made to the above sections of the Operations Procedures Manual since the date of Glen's death, the issue identified by the investigator had not been clarified at the time of final submissions.

174. Mr Raper accepted that there was a tension in the Operations Procedures Manual between section 12.1.5 and section 13.2. He said the Operations Procedures Manual was currently being reviewed and that something coming from this inquest could potentially have some impact on that.

175. While on the face of it there is an inconsistency from a lay perspective (it was considered safe to open Glen's cell with only 2 officers present when Inmate Baglee was returned from court yet considered unsafe to reopen it some minutes later unless 3 officers were present) there are other factors. Correctional Officer Neal knew Inmate Baglee to be cranky but not violent and one could have some understanding as to the reasons why Inmate Baglee was agitated when the officers first came back to the cell on the alarm being given by him. However Correctional Officer Bender was a new officer and Correctional Officer Redfern said she did not know either inmate that well. They were both worried about Inmate Baglee's agitation and because Glen was lying down on his bed they were concerned the situation was a "set up". Further it is a maximum security wing of the facility. I cannot be critical of the officers in that situation. I hope however that the findings in this inquest will provide some impetus for executives of Corrective Services to review the policy to make it clearer for staff at times of emergency such as this.

What Corrective Services policy governs the distribution of mail to inmates (including if the inmate may be subject to an ADVO).

176. The issue was whether Glen had been deprived of correspondence from his de facto partner, as from his own letters the absence of correspondence from her appears to have affected his state of mind at times. Ms Te-Wake told investigators that the first of her letters to Glen was returned with a letter that originated from Glen, which suggests that

he received that first letter from Ms Te-Wake. Other letters that Ms Te-Wake recalls sending were not returned; it is not known what happened to those letters. Assistant Superintendent White gave evidence that Glen did not raise the issue of missing mail with her.

177. Mr Raper said that if Corrective Services was aware that a current ADVO prohibiting contact was in place, it would look at intercepting correspondence from the person in need of protection, returning that correspondence and advising why it had been returned. That does not appear to have been the case in this matter. There does not appear to be a formal policy that directly addresses the issue.

178. Counsel Assisting asked Mr Mumford about the effect of ADVOs on inmates' contact with persons outside the gaol, including calls and letters. Mr Mumford gave evidence that he checked return of property for Glen (for letters and the like) and found nothing there. A letter could be returned to sender if there was an apprehended domestic violence order in place stating 'no contact'. It would be returned to sender and there would be a record made in a register.

179. The evidence at the inquest did not reveal why, if letters had been sent to Glen, they did not reach him. That they did not is evident from his own letters where he asks Ms Te-Wake why there had been no contact.

Expert Evidence of Dr Christopher Ryan:

180. Dr Ryan, a senior staff specialist at Westmead Hospital, is a well-regarded psychiatrist who gave evidence at the inquest. He said that suicide is a very rare event, even in an inpatient setting. He said that only a very small number of patients who are assessed as being at a high risk of suicide will actually go on to complete suicide and that people who are assessed as low-risk may still complete suicide, with the utility of risk assessment somewhat questionable in terms of assigning people categories ranging from low to high. The doctor acknowledged that it was common for people to self-harm with no intention of ending their lives. He said that competent people who don't want help, can't be forced to accept it, and that you have to create an environment where people will be comfortable coming forward and seeking help. He added that, if the stressors on a person flow from personality type and substance use, their state of mind so far as suicidal ideation is concerned can change enormously from day to day.

181. Dr Ryan was of the view that there was a paucity of good psychiatric assessments in Glen's medical records and said that, based on those records, he wasn't able to come to a view that Glen definitely had any particular psychiatric condition aside from substance use disorder and, probably, some form of personality problem.

182. The doctor indicated that people think about ending their lives for a range of reasons, usually in response to some form of crisis (a "crisis" meaning that the stresses the person is facing are overwhelming their resources). It would seem likely, based on the doctor's evidence, that Glen was experiencing at times a situational crisis which included his incarceration and separation from his partner and her children, which was a major feature of his letters to her.

Findings:

183. All witnesses who gave evidence at the inquest were honest, candid and helpful, other than the comment that I have already made in relation to Nurse Wells.

184. I find on the available evidence that Glen's death was self-inflicted. I adopt and find the cause of death as disclosed in Dr Cala's reports, being asphyxia from neck compression, consistent with the mechanism of self-inflicted ligature strangulation.

185. There is some evidence in Glen's letters to his partner from which an inference can be drawn that at times proximate to his death he was expressing suicidal ideation. This ideation was not, on my findings, communicated to any correctional officer or Justice Health nurse within the Cessnock Correctional Centre. On my findings, there was no direct evidence of suicidal ideation shown by Glen or communicated by him or observed by any officer or nurse.

186. Glen died in his cell number 15 sometime between lock-down at 3:20 pm and the return of his cell-mate to the cell at about 7:50pm on 27 April 2015, at Cessnock CC. Based on the material provided to him, in the opinion of Dr Cala he would completely discount that Glen's death occurred in the 10 minutes or so prior to the arrival at his cell of Corrective Services officers and Justice Health nurses so that the latest time is around 7.40 pm.

187. Despite those matters that have been found at the inquest to have not been correctly undertaken, the evidence does not provide a foundation for concluding that a different outcome would have occurred if the deficits identified had not occurred.

188. Whilst no individual staff member can be singled out for strong criticism at Justice Health, there was a comprehensive failure to organise the starting of Glen's medication in a timely fashion. Further it would have been, in hindsight, advantageous to have asked more questions of Glen, particularly about his arm and the aspect of self-harm.

189. I am concerned at the differing levels of interpretation shown concerning priority levels under the PAS system. While I am aware from submissions made by counsel for Justice Health that this matter is being reviewed and is "already developed to an advanced stage" I still consider the matter warrants a recommendation. While it is a system improvement and the cause of death cannot be directly attributed to any perceived deficit in the screening process, it arose in consideration of the manner of death and in that broader sense is "connected with the death " (see s 82 (1) *Coroners Act 2009*).

190. I find that staffing levels of Justice Health nurses were under pressure at the time of Mr Russell's death. I have an understanding concerning the difficulty they are experiencing in recruiting qualified staff to a rural location such as Cessnock. I will not be making a recommendation in relation to funding resourcing where it was really not a direct issue at the inquest nor am I aware of the state-wide allocation of resources. At the inquest the focus was on nurses and not in terms of the broader area of mental health resources. I do consider it appropriate that I ask Justice Health to review its processes and staffing particularly at Cessnock CC where I am aware there is now an increase in inmates.

191. One of the unknowns is the extent to which suicidal ideation expressed on one day may be regarded as resolved (and the need for supervision consequently removed) if the patient the next day is not expressing current thoughts. Another unknown is whether

Glen would have shared such thinking with a clinician. The "pinpoint in time" approach to assessment, even taking past history into account, may not have suggested a level of concern warranting an extended RIT. Glen's history of self-harm would not have necessarily been conflated with the risk of taking his own life, from a clinical perspective. Even an extended RIT is unlikely to have persisted beyond days rather than weeks, on the available evidence.

192. Ms MacCameron's assessment, as a qualified mental health nurse who considered the recent self-harm act as part of her assessment, concluded that Glen was not at immediate risk of suicide. A distinction needs to be drawn between a person's thinking as at shortly prior to admission into custody and what that thinking might be seven weeks later.

193. Given the restrictions on patient access in a correctional setting and the inability to frequently and effectively monitor the prison population at large, the need for an accurate mental health nurse assessment priority rating in PAS and the need for consequent adequate mental health assessment assumes much greater significance in a correctional setting.

194. Given that the Kessler 10 survey and follow-up questions with respect to self-harm were not mandatory, together with Glen's denial of current self-harm, it could not be concluded that the assessment conducted by Nurse Henderson was inadequate, although it would clearly have been desirable with Glen's reported history to ask the follow-up questions about self-harm and to conduct a Kessler 10 survey. However, had Nurse Henderson done so, given Glen's claim not to have self-harmed with his current injury, it could reasonably be inferred that he was unlikely to be candid in response to the follow-up questions or a Kessler 10 survey.

195. I have already commented on the amending of the RSA form given the evidence of Ms Sheehan and Ms Pavey about the asking of the follow-up questions in relation to self-harm. (see paragraph 94 of this decision).

196. While it was outside the scope of evidence covered in this inquest, the issue of "current presentation" for mental health in the RSA should not be simply the presentation of the patient on the day of assessment. In my opinion it should be a gathering of information from the patient over the last few weeks prior to their incarceration.

197. I have already mentioned the importance of obtaining collateral information and I again draw to the attention of Corrective Services the appropriateness of obtaining and recording third-party information such as given by Ms Fielder-Gill. Perhaps telephonist reception staff should be given access to add notes on the OIMS system or alternatively some procedure put in place whereby staff can record concerns as expressed by Ms Fielder- Gill. Better still it would be prudent to make some enquiries with outside sources such as family members or other people that the inmate places trust in. That is why attention should be given to further training to ensure that screening officers are aware of the basis for the screening phone call to family to be requested and, if approved, made. It should not simply be to permit family contact but it is crucially important to obtain collateral information particularly so in circumstances where an inmate may be reluctant to divulge current thinking (for example knowing that he or she might be placed in a safe cell under an RIT).

198. In the table attached to the Corrective Services Commissioner's submissions, some matters have already been accepted and are or will be implemented. Mental health training particularly for staff carrying out the screening process has now been incorporated into the preliminary training of correctional officers at their training academy called "Brush Farm".

199. The Commissioner agrees that further mental health training is an advantage and should be included and I commend that response. It has also been accepted that scenario-based training is to be made available to staff with the prior arrangement of the governor at each centre.

200. I note that the Commissioner is also going to make clearer the policy in relation to mail where there are ADVOs in place against inmates.

201. The Commissioner also agrees with the proposal to encourage searching officers to relay information about signs of injury to the officer filling in the Reception Checklist.

202. At the conclusion of the inquest Glen's mother Narelle Jarvis provided some insight into her son who she dearly loved. Ms Jarvis expressed the sentiment that no parent or family should have to go through what her family had gone through or feel the pain that she and her family have had to endure. She had thought on Glen's last release from custody and with the assistance from Ms Fielder-Gill that he was happy for the first time in a long time, particularly in re-establishing a connection with her and other members of the family. She said he would give you the shirt off his back if it meant to help. He would go out of his way to help anyone, always putting others before himself. She said he was a loving, caring and passionate person who put 110% into everything he did in life despite what he had been through. She said that he had made mistakes – stupid silly mistakes but he had learnt from them.

203. I sincerely hope that the process of this inquest has provided to Ms Jarvis some feeling of comfort that his death, while tragic, has brought some significant changes to the way in which people will be assessed and treated in future in a custodial setting. From his death other people have learned from their mistakes and that is a very important matter and one that Ms Jarvis can feel from which there is a significant and lasting benefit.

204. I extend again my sincere condolences to Ms Jarvis and her family on the death of her much loved son.

205. I take this opportunity of thanking the officer in charge of the investigation Detective Sergeant Babb. I acknowledge the great help and assistance of Counsel Assisting, Mr Peter Aitken and his instructing solicitor Ms J Natoli from the Crown Solicitor's Office. The help of other Counsel and solicitors who represented persons of interest is also gratefully acknowledged and appreciated.

206. I am also grateful for the manner and way they approached the inquest and the assistance they gave to me.

Formal Findings:

I find:

A. The date of death was on 27 April 2015;
B. The time of death was between 3:20 PM and approximately 7:40 PM;
C. The place of death was cell 15, G 3 pod, Cessnock Correctional Centre;
D. The cause of death was asphyxiation arising from neck compression;
E. Manner of death: Glen Russell died after using torn or cut up pieces of a bed sheet to make a ligature, which he tightened around his own neck while lying on his bed with the intention of ending his life.

Recommendations:

To Justice Health:

I. That the current template for the "Reception Screening Assessment" form, in circumstances where the patient answers "yes" to any of the 3 mandatory questions under the heading "Suicide risk assessment", be amended to also mandate that the clinician record answers to the further clarifying questions set out under that mandatory question;

II. That the current proposed clarification of the patient appointment priority rating categories from 1 – 5 on the "Patient Administration System" include clarification of the rating categories so far as they apply to patients requiring mental health assessments.

To the Commissioner for Corrective Services:

I. That the current ongoing revision of the Operations Procedures Manual (or its replacement, as the case may be) include clarification to Corrective Services officers on the interaction between (a) the safety and security requirements for officers opening cells in response to a cell alarm in maximum security centres and (b) the duties of a first responding officer in a potential death in custody situation.
II. That consideration be given to amending the current CSNSW "Intake Screening Questionnaire", to ensure that currently consolidated questions concerning self-harm and suicide (both current plans and previous acts/attempts) are separated into separate questions as follows:

- Do you have any current plans to hurt yourself?
- Do you have any current plans to end your life?
- Have you ever previously tried to hurt yourself?
- Have you ever previously tried to end your life?

III. That consideration be given to amending the current consolidated question in the CSNSW "Reception Checklist" concerning "current thoughts of self-harm/suicide" to have two discrete questions, one addressing current thoughts of self-harm and one addressing current thoughts of suicide. (I note from the Commissioners submissions that this has already been revised).

Deputy State Coroner R G Stone
Coroners Court
Newcastle