REPORT BY THE NSW STATE CORONER

into deaths in custody/ police operations

2000

(Coroner's Act, 1980)

attorney general's department of new south wales

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The Honourable Robert John Debus
Attorney General of New South Wales
Level 20, Goodsell Building
8-12 Chifley Square
SYDNEY NSW 2000

24 January 2001

Dear Attorney,

In accordance with the provisions of Section 12A(4) of the Coroners Act 1980, I present a written report containing a summary of the details of the deaths of persons in circumstances referred to in Section 13A.

Under the provisions of Section 13A:

1. A Coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that the person has died or that there is reasonable cause to suspect that the person has died:

   (a) while in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody; or

   (b) as a result of or in the course of police operations; or

   (c) while in, or temporarily absent from, a detention centre within the meaning of the *Children (Detention Centres) Act 1987*, a prison within the meaning of the *Prisons Act 1952*, or a lock-up, and of which the person was an inmate; or

   (d) while proceeding to an institution referred to in paragraph (c) for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care and custody.

2. If jurisdiction to hold an inquest arises under both this section and Section 13 (class of deaths which must be reported to the Coroner), an inquest is not to be held except by the State Coroner or a Deputy State Coroner.

Inquests into such deaths are mandatory and must be heard by the State Coroner, or a Deputy State Coroner. It is therefore part of the *Coroners Act* that deaths resulting from police operations, deaths in prisons, and deaths of persons proceeding to and from appropriate institutions are to be the subject of mandatory reporting and inquest, although in practice such was always the case.

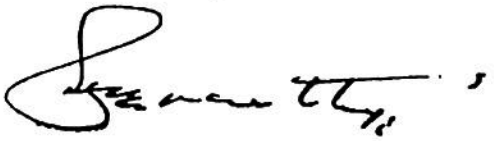
81 cases in circumstances referred to in Section 13A were subject to investigation by the State Coroner and his Deputies in 2000 and are referred to in this report. Of those 81 cases, 42 were matters outstanding as at the 31 December 1999 and 39 were matters reported during 2000.

In 2000, 32 matters have been completed by way of Inquest finding, 3 of which were found not to be reportable to the Coroner under Section 13A. 8 have been terminated because of person/s being charged with an indictable offence in which an issue will be that the person caused the death. Of the 41 outstanding matters, 5 cases have been listed for hearing in 2001 and 36 are currently under investigation with hearing dates yet to be allocated.

It had been my intention to review the format and contents of this report. Unfortunately illness has intervened.

I hereby enclose my report for 2000 into deaths in custody/police operations deaths for your information and for the information of both Houses of Parliament.

Yours sincerely,

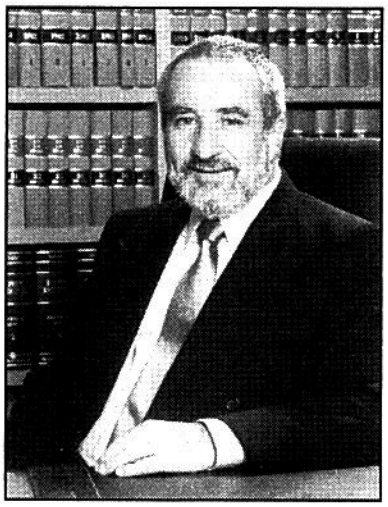


J B Abernethy

NSW State Coroner

STATUTORY APPOINTMENTS

Under the 1993 amendments to the *Coroners Act 1980*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The deaths, the subject of this report, were conducted before the following Coroners:



MAGISTRATE JOHN ABERNETHY
New South Wales State Coroner

1965 Joined the (then) Petty Sessions Branch of the New South Wales Department of the Attorney General and of Justice

1971 Appointed Coroner for the State of New South Wales

1975 Admitted as a Barrister-at-Law in the State of New South Wales

1984 Appointed a Stipendiary Magistrate for the State of New South Wales

1985 Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982

1994 Appointed New South Wales Deputy State Coroner

1996 Appointed New South Wales Senior Deputy State Coroner

2000 Appointed New South Wales State Coroner

MAGISTRATE JANET STEVENSON
Senior Deputy State Coroner

1990 Magistrate and Coroner

1997 Deputy State Coroner

2000 Senior Deputy State Coroner

MAGISTRATE JACQUELINE MILLEDGE
Deputy State Coroner

1996 Magistrate and Coroner

2000 Deputy State Coroner

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Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to the Royal Commission into Aboriginal Deaths in Custody recommendations, that a definition of a death in custody should, at the least, include[1]:

1. the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

2. the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;

3. the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

4. the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Section 13A of the *Coroners Act* expands on this definition to include circumstances where the death occurred:

1. while temporarily absent from a detention centre, a prison or a lock-up; as well as

2. while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in police custody or during the course of police operations. This is a matter for determination by the Coroner after all the evidence and submissions from those granted leave to appear have been presented at the inquest hearing.

What is a death as a result of or in the course of a police operation?

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely deaths 'as a result or in the course of a police operation' as referred to in Section 13A of the Act.

[1] *Recommendation 41. Aboriginal Deaths in Custody: Responses by Government to the Royal Commission 1992 pp 135-9*

The circumstances of each death will be considered in reaching a decision whether Section 13A is applicable but potential scenarios set out in the Circular were:

- any police operation calculated to apprehend a person(s);
- a police siege or a police shooting
- a high speed police motor vehicle pursuit
- an operation to contain or restrain persons
- an evacuation;
- a traffic control/enforcement;
- a road block
- execution of a writ/service of process
- any other circumstance considered applicable by the State Coroner or a Deputy State Coroner

The Deputy State Coroners and I have tended to interpret the subsection broadly. We have done this so that the adequacy and appropriateness of police response and police behaviour generally could be investigated where we believed this was necessary.

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police. It is important that the relatives of the deceased, the New South Wales Police Service and the public generally have the opportunity to become aware, as far as possible, of the circumstances surrounding the death.

In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police was found not to warrant criticism by the Coroners. However criticism of certain aspects were made in the following matters:-

- 1475/99 where the Acting Deputy State Coroner stated that the police were not entitled to bolster the 'suspicion' which they had formed in their own minds by a search of a vehicle. He also held that the statutory powers relied on by the police were not were not relevant on the facts of this case.
- 1910/99 the Deputy State Coroner criticised the pursuit that took place.
- 502/00 the State Coroner noted that the current Domestic Violence Policy and Standard Operating Procedures document was deficient.

In the following matters the actions of the police were commended:-

- 2351/98 the State Coroner found the police actions to be carried out professionally and in accordance with public expectations, he commended the officer for the manner in which he undertook these responsibilities.
- 1122/99 the Acting Deputy State Coroner commended the Senior Sergeant and the other members of his critical incident team for the excellent quality of the brief they prepared, which was completely thorough, objective and professional.

- 4/00 the Deputy State Coroner found the police response was not only timely and appropriate, but stated "the police that dealt with that incident are police that the constabulary can certainly be proud of".

We will continue to remind both the Police Service and the public of the high standard of investigation expected in all coronial cases.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

I agree with the answer given to that question by Mr.Kevin Waller a former New South Wales State Coroner.

> The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated[2].

I agree also with Mr.Waller that:

> In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined[1],

New South Wales coronial protocol for deaths in custody/police operations

Immediately a death in custody/police operations occurs anywhere in New South Wales, the local police are to promptly contact and inform the duty operations inspector (the DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required to immediately notify the Senior Deputy State Coroner (Westmead) if the death occurs within the jurisdiction of the Westmead Coroner's Court which covers the western areas of metropolitan Sydney. The State Coroner or Deputy State Coroner must be notified of all deaths which do not fall within that area. These three Coroners are on call twenty-four hours a day, seven days a week. The Coroner so informed, and with jurisdiction, will assume responsibility for the investigations into that death.

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[2] *Kevin Waller AM., Coronial Law and Practice in New South Wales, Third Edition, Butterworths, page 28*

[1] *Kevin Waller AM., Waller Report (1993) into Suicide and other Self-harm in Correctional Centres, page 2.*

The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

The DOI is also required to immediately notify the Commander of the State Coroner's Support Section, a small team of police officers who are directly responsible to the State Coroner for the performance of their duties.

Upon notification by the DOI, the State Coroner or Deputy State Coroner will give directions that experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section) and the local government medical officer or a forensic pathologist attend the scene of the death. The Coroner will check that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit (officers of the Physical Evidence Section) and the local government medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practical, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. The Support Group Officer will continue to liaise with the Coroner and with the police investigators during the course of the investigation. In the course of the investigation the Coroner will, if necessary, direct investigators.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner will request the local Coroner in the particular district, and the local Government Medical Officer attend the scene.

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operations are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the police

When informed of a death involving the police service, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroners may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigations into the death. This course of action is considered necessary to ensure that justice is done and seen to be done.

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigations being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner. Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences will often take place between the Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

Apart from deaths in custody/police operations which occur in the Newcastle and Westmead Coronial districts (areas which are served by full-time pathologists), the remains of those who died in custody/police operations elsewhere in the State are transported by government contractor to the New South Wales Institute of Forensic Medicine at Glebe for post mortem examination by experienced forensic pathologists.

Responsibility of the coroner

Section 22 of the *Coroners Act* provides:

1. the Coroner holding an inquest concerning the death of a person shall at its conclusion record in writing his findings as to whether the person died and if so

    - identity of deceased
    - the date and place of death; and
    - the manner and cause of death,

Section 19 provides that:

1. if the Coroner is of the opinion that the evidence given at the inquest establishes a prima facie case against any known person for an indictable offence; and

2. the indictable offence is one in which the question whether the known person caused the death is in issue the Coroner must terminate the inquest.

The inquest is terminated after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner and specifying the name of the known person and the particulars of the offence.

An inquest is an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

Deaths in custody are personal tragedies and have attracted much public attention in recent years. A Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill-treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management or

physical surrounds which may reduce the risk of suicide in the future. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, to ensuring, as far as possible, that remedial action is taken.

Recommendations

The common law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation in Section 22A of the *Coroners (Amendment) Act 1993*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations (S.22A(2)).

Any recommendations made following an inquest hearing should arise from the facts under inquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. Coroners require, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of the receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly. Some weeks are required for the inquest evidence and exhibits to be studied and consideration given to the recommendations made by the Coroner. A formal reply as to the outcome of those considerations is then received by the Coroner. Recommendations were made arising from 14 inquests held during 2000.

Contacts with outside agencies

During 2000 the State Coroner's office maintained effective contact with the New South Wales Institute of Forensic Medicine (Department of Health), the Division of Analytical Laboratories at Lidcombe (Department of Health), the Aboriginal Justice Advisory Committee (New South Wales Attorney General's Department) the Aboriginal Deaths in Custody Watch Committee, the Indigenous Social Justice Association, the Aboriginal Corporation Legal Service, the Aboriginal and Torres Strait Islander Commission, the Australian Institute of Criminology in Canberra, the Office of the State Commander New South Wales Police Service, and the Department of Corrective Services. Close links were also maintained with Senior Coroners in all other states and territories.

Overview of deaths in custody/police operations reported to the New South Wales State Coroner during 2000

All deaths pursuant to Section 13A of the *Coroners Act 1980*, must be investigated by the State Coroner or a Deputy State Coroner.

Deaths in custody/police operations which occurred in 2000

There were 19 cases of deaths in custody and 20 cases of death as a result of or in the course of police operations reported to the State Coroner in 2000. Of these 6 inquests were terminated - 1 "death in custody" and 5 "police operation deaths". One matter which was reported to the Coroner as a death in "police operation" was assessed at inquest not to be reportable under section 13A*. The remainder have either been listed for hearing in 2001 or are still under investigation.

Year	1995	1996	1997	1998	1999	2000
Deaths in Custody	23	26	41	29	27	19
Deaths in Police Operation	14	6	15	9	7	20*
Total	**37**	**32**	**56**	**38**	**34**	**39**

Table 1: Deaths investigated by Coroners during 1995 to 2000

Aboriginal deaths which occurred in 2000

Of the 39 deaths reported during 2000 pursuant to Section 13A, Coroners Act 1980, 5 of the deceased were adult aboriginal males. Of the five aboriginal adult males, 4 died in custody in prison and one died during a police operation.

The inquest into the death of one adult aboriginal male has been heard and a finding given, a synopsis for this death is contained in this report. The deaths of the remaining 4 adult aboriginal males are being investigated.

Year	1995	1996	1997	1998	1999	2000
Deaths in Custody	7	2	6	2	3	4
Deaths in Police Operation	0	0	2	3	1	1
Total	**7**	**2**	**8**	**5**	**4**	**5**

Table 2: Aboriginal deaths in custody/police operations during 1995 to 2000

Deaths investigated by the State/Deputy State Coroners during 2000

During the year 24 cases of "deaths in custody" (of which 1 related to police custody) and 16 "police operation deaths" were finalised (Appendix 1).

Findings were recorded as to identity, date and place of death, and manner and cause of death. At inquest, two "deaths in custody" and one "police

operation death" were found not to be reportable under s13A of the Coroner's Act and therefore not assessed as such. No findings were entered as to the manner and cause of death in 2 "deaths in custody" and 6 "deaths in police operations" as the inquest in each case was terminated under the provisions of Section 19 of the Coroners Act 1980, on the basis that a known person had been charged with an indictable offence in which an issue will be that the known person caused the death.

Of the remaining 41 cases 5 have been listed for hearing in 2000 and investigations are still proceeding in the remaining 36 matters.

Information relating to the 34 deaths into which inquests were held and the 6 deaths in which the inquests were terminated

Circumstances of death

Persons who died in the custody:-

- 13 by taking their own life by hanging (1 in police custody)
- 2 by way of homicide
- 4 by way of accidental drug overdose
- 3 of natural causes
- 2 Not reportable under s13A

Persons who died as a result of or in the course of police operations:-

- 9 from injuries received whilst in a vehicle being pursued by police
- 2 shot by police
- 1 self inflicted gun shot wound
- 1 by taking their own life by hanging
- 1 by taking their life by ingesting poison
- 1 multiple injuries incurred as the result of a fall
- 1 not reportable under s13A

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is unavoidable. There are many different reasons for delay.

One 1995 matter remains outstanding - the inquest is part heard before the then Senior Deputy State Coroner, John Abernethy who adjourned the matter generally for further investigation to be undertaken on his behalf.

One 1997 matter remains outstanding - the inquest is part heard and has been adjourned to for a further 2 days in March 2001.

Four 1998 matters remain outstanding - 2 of these deaths are still being investigated and 2 have been listed for hearing early in March 2001.

The view taken by the State Coroner is that deaths in custody/police operations must be fully investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as complete as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case. It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services. The result of that investigation may have to be considered by the Coroner prior to the inquest as it could raise further matters for consideration and perhaps investigation.

In some cases an expert medical or other opinion may be obtained. This will necessarily require the selected expert to read and assess the whole file before providing the Coroner with an independent report.

The concerns of the family and relatives of the deceased and possible other interested parties must also be fully addressed.

In the case of country deaths, delay can sometimes occur due to the un-availability of a suitable courtroom as the result of Supreme, District or Local Court commitments in a particular district.

Deaths occurring in police custody or during the course of police operations demand compliance by officers with the NSW Police Service Handbook as they relate to such a death. The Crown Solicitor instructs independent Counsel to assist with the investigation of this type of death. The official police instructions are closely analysed by the Coroner.

SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2000

Following are brief summaries of each of the cases of death in custody/police operations which were heard by the State Coroner, Senior Deputy State Coroner, Deputy State Coroner and the Acting Deputy State Coroner in 2000.

These summaries include a description of the circumstances surrounding the death, the Coroner's findings and any recommendations that were made.

Further information about any of these cases can be obtained from the Executive Officer to the NSW State Coroner, Coroner's Court, Glebe.

753 of 1998 — A male of 36 years died on 15 April 1998 in the Dock at Bellingen Police Station. Finding handed down on 20 April 2000 at Glebe by Dr Elwyn Elms, Acting Deputy State Coroner

Detectives J and A were in the Federal Hotel Bellingen carrying out an under cover operation when they were recognised as police officers by P. He abused and allegedly spat at and assaulted one of them. He was arrested and an unseemly struggle ensued as P, resisting all the way, was physically manoeuvred along the street to the police station, which was about 100 metres from the Hotel. Once inside he was detained in the enclosed dock where he would remain for almost two hours until he was found hanged by a remnant of his shirt.

The circumstances leading to P's death

Detectives J and A arrived at the Federal Hotel Bellingen on 15 April 1998 at about 2.45 pm. According to their evidence, they witnessed a drug deal in a lane adjacent to the hotel, and resolved to enter the hotel in order to carry out further observations. For this purpose, they initially went to the rear of the hotel. Then, seeing nothing, they moved to the front bar of the hotel, ordered a drink and sat down thereby exposing their guns, encased in holsters strapped to their ankles, below their trouser legs.

This brought them to the attention of P, who immediately subjected them to a tirade of abuse containing many unseemly words, and showed saliva in his mouth at them. At this point, the publican, Mr. V, intervened, and escorted P to a table on the verandah at the side of the hotel. V returned and was apologising to the police, when, according to the latter, P resumed his abuse from the door. This version was not supported by other witnesses.

Taking separate routes – one through the front door and the other via the beer garden -J and A moved to the beer garden area and again approached P. They said that P spat and lunged at them, whereupon they proceeded to place him under arrest for assaulting police.

The Acting Deputy State Coroner (hereinafter referred to simply as 'the Coroner') was critical of the decision to arrest P. He said the abuse was directed at them, not at any other member of the public. V's actions had ensured that the two parties were no longer in the immediate vicinity of each other, and at that point, said the Coroner, the two police officers should have

withdrawn. According to J, V had made a remark tending to suggest that P was known to him beforehand.

Enquiries could have been made about P's identity, and even if P was unable to furnish full details, the chances are that P would not have been too difficult to identify, with his red hair and tattoos. Process could then have been issued against P after the event for the offence of offensive language in the front bar of the hotel. This was an offence which does not even carry a goal sentence.

It would only be in exceptional circumstances, and for present purposes the Coroner said that he could not conceive of any, that a person should be arrested for an offence which does not carry a custodial option. Not every situation the police are confronted with has to end up in a confrontation with an arrest as the logical conclusion. Discretion and knowing the occasion for a tactical withdrawal are important appointments in the armoury of a police officer, and the Coroner said so bearing in mind his general experience on the bench where he had presided over cases where the police had done just that.

Of course, in the circumstances of this case, the police said that they were not arresting P for the offence of offensive language, but for assault, bearing in mind what happened on the verandah. On the evidence before him, the Coroner could not be satisfied that the incident there occurred in the manner the police said it did, whatever standard of proof is applied, bearing in mind the evidence given by civilian witnesses.

In any event, P was arrested, and thereafter an unseemly struggle ensued as the police attempted to physically manoeuvre P from the Hotel to the police station. P resisted the whole way, at times violently and at other times by dropping his weight to the ground. This struggle was witnessed by a large number of the citizens of Bellingen, many of whom gave statements and some of whom gave oral evidence in the proceedings.

During the struggle, A's gun came adrift from his ankle holster. Both detectives said that P was attempting to grab it during the struggle and that P actually took hold of it. Again, bearing in mind the evidence of civilian witnesses, the Coroner took the view that any tribunal of fact attempting to resolve the issue as to what happened to the gun during the struggle would have some difficulty in being satisfied that P actually took hold of the gun.

Meanwhile, the struggle progressed to the police station, where Senior Constable F had received a 000 phone call at 3.05 pm to the effect that there was a fight outside the police station. At about the time she emerged, P requested his puffer, which the detectives retrieved from his pocket. He took a puff and threw it away. F had some success in calming P because she knew him. The detectives released their hold, but P punched J to the stomach area and kicked him in the groin, whereupon A shoulder charged him over the front fence.

Once inside, after a struggle lasting about ten minutes, P was placed in the holding dock, which was padlocked and bolted, and where he would remain for some 1 ¾ hours until he was found hanged around 5.00 pm. The dock was of the Lexan variety, fully enclosed in Perspex, except at the top where

there was a gap, which, unbeknown to the police involved in this case, housed a number of hanging points. This form of dock can come into use after the cells at Bellingen were decommissioned. It was never intended that prisoners be housed there for any length of time.

In the meantime, Detective J telephoned V (the publican) and asked him to come to the station and make a statement. Because of his personal involvement in the circumstances of Mr. P's arrest, he also phoned Coffs Harbour asking for an independent officer to come to Bellingen to be the informant.

At 3.25 pm, F rang Coffs Harbour Police Station and sought permission to be the Custody Manager to satisfy the requirements of the Crimes Amendment (Detention After Arrest) Act 1997, which had come into force on the previous 9 February. This permission was granted by fax at 4.03 pm. At 3.30 pm, she took Detective A to the Bellingen Hospital in order to have his finger, which had been injured in the struggle, attended to.

At 3.40 pm, A arrived and was seen by hospital staff. At the same time, Detective J2, who was in Sawtell (about 10 kilometres south of Coffs Harbour and half an hour from Bellingen), was contacted and asked to go to Bellingen to interview P and otherwise investigate the matter. He left immediately, drove to Coffs Harbour to obtain a vehicle with prisoner carrying facilities, and then returned to Sawtell in order to obtain a video camera. He then drove to Bellingen, arriving at 4.40 pm. In the meantime, Mr. V had arrived and F commenced taking his statement in a front room of the police station removed from the charge room where Mr. P had been detained.

Upon entering the charge room, J2 saw P hanging from his neck in the dock by a blue flannelette shirt. He attracted F's attention and with V's help, they lowered P, and attempted to perform CPR without success. At 5.08 pm, Dr H arrived and pronounced life extinct death being estimated to have occurred within the last ten to fifteen minutes.

At about 6.00 pm, A was seen by a doctor at the hospital. X-rays resulted in a diagnosis of a compound fracture of a finger to the left hand and a fracture of the right. Following this attendance, he and J, whom J2 had earlier driven to his car to pick up A from the hospital, set off for Coffs Harbour, but they soon received a directive to return to the Bellingen Police Station, which they did. They subsequently left there at about 8.00 pm.

The effect of this chronology, which the Coroner found as a fact, was that when P died, the only persons in the police station were J2, F and V. He was satisfied that at the relevant time, J and A were at the hospital. He rejected any suggestion that there was anyone else involved in Mr. P's death other than P himself.

Whilst he was in the dock between 3.15 pm and 5.00 pm, P was constantly swearing, screaming abuse and kicking the dock. In the early stages of his detention, he became particularly agitated whenever Detective J entered the room. Whenever F entered, she exercised a calming influence upon him. However, as Mr. B (counsel assisting the Coroner) noted, his behaviour was

characterised by a progressive deterioration in his condition: at times aggressive and emotionally out of control, at others despairing and crying silently, asking for air, asking 'where do I fit in?', where can I go where I don't get harassed?' The significance of this behaviour was not appreciated by Constable F or indeed any of the police officers who observed Mr. P on that day.

It was suggested to Senior Constable J that he was keeping P in the dock purely to humiliate him. It was submitted that a finding should be made that the police officers acted with reckless indifference to his safety. However, the Coroner was not satisfied that he should make such a finding. The legal concept of recklessness involves foresight of consequence coupled with a willingness to take the risk nevertheless.

He was quite satisfied that the police officers did not appreciate the significance of Mr. P's behaviour or that he presented a risk to himself. Further, there were reasons for keeping him confined so long, unsatisfactory though that situation was: the need for an independent informant to come from Coffs Harbour to investigate the matter and to deal with aspects of bail, and the fact that his violence made it impractical to place him in a police truck and take him to Coffs Harbour directly. The Coroner rejected the submission that P should have been placed in a decommissioned cell, noting that it would not have been within the discretion of Senior Constable F to have done so.

Issues

1. Why was P not assessed as a suicide risk?

As regards the assessment of P as a suicide risk, the relevant criteria for screening prisoners were set out in the now superseded Police Commissioners Instruction 155.

Having regard to the 'fairly obvious warning signs' which P displayed which are fully itemised in the Commissioner's Instructions, the Coroner said that it was indeed remarkable that none of the officers involved twigged to the fact that P was a potential suicide risk. The symptoms portrayed virtually a classic case.

As Mr. B submitted, J and A adhered to the rather simplistic notion that P presented a threat to them rather than himself. For her part, Senior Constable F was comforted by the fact that she had a calming influence upon him and was able to communicate with him. She also said during her oral evidence, referring to an occasion when Mr. P appeared to be trying to exit the dock from the gap at the top: 'I did not think he was going to kill himself. He was trying to get out'.

Detective J said that he didn't have the necessary training to be able to detect a suicide risk, and both Senior Sergeant R and Inspector B made the point that police were not trained as psychologists or social workers. Whilst that may be so, the symptoms made by P were 'fairly obvious warning signs' which were at the relevant time meticulously documented in the Police Commissioner's Instructions, and which, had it been read and appreciated

should have served serve as a warning to the police officers that, at the very least, some form of risk assessment was warranted. The problem was that the Commissioner's Instructions sat on the mantle piece at the Coffs Harbour and Bellingen Police stations and were only consulted on an 'as required' basis.

Notwithstanding that the police officers may not themselves have recognise the fact that P presented a suicide risk, the documentary processes which were required to be filled out following his arrest and confinement contained their own inbuilt procedure for risk assessment and the proper completion of these forms should have served to warn them that P presented as a potential risk as one who may harm himself. Before the advent of the on-line Charge Management system, the Prisoner Admission Management Form (PAMF) was completed manually.

'With the development of the Charge Management system, the Prisoner Admission Management Form (PAMF) was integrated into the on-line Custody management system through the (Police) Service's central mainframe. To assist police identify prisoners who may be at greater risk of injury or self-harm, or who may have a pre-existing illness which may exacerbate their risk potential, a three tiered assessment device, the 'Personal Assessment details" (PAD) was built into the custody record. Part one of the PAD is the 'Brief Assessment", prepared from the answers to two questions asked of the arresting or transporting police. Part two, the 'Brief (*Sc: Visual*) Assessment', consists of a series of observations made by the custody officer. Part three, the 'Questionnaire', are questions asked of the prisoner by the custody officer.' (Sergeant R, Statement, par 5)

The only difference between this and the previous manual system was that under the on-line system, until one field had been filled out (the Brief Assessment) one could not access the next (eg the Visual Assessment). In the present case, apart from a notation that the defendant was 'upset and aggressive', the assessment never progressed even to the stage of Brief Assessment. This was still up on the screen at the time of P's death, not having been entered for the purpose of completion. It is clear from Sergeant R's evidence that the responsibility of completing the Brief Assessment was that of the arresting police. Once P had been placed in the dock, Detective J assumed that it was Constable F's responsibility as Custody Officer.

Further, the Commissioner's Instruction says that a PAMF is to be completed 'after conveying a prisoner to a police station and a bail determination has been made and the prisoner is to remain in custody'. In P's case, no such determination was ever made. Senior Constable F said that it was 'pretty obvious' that bail would be refused, but no formal determination was ever made.

There were, of course, reasons for this. Constable A was preoccupied with the necessity for treatment to his hand and left the police station for this purpose. Senior Constable J wanted someone independent to take over the conduct of the matter in view of his own involvement, and there was a delay while that person, Senior Constable J2, came from Sawtell and Coffs Harbour. After making his inquiries and interviewing the defendant, it seemed that it would be he who would consider the question of bail. Senior

Constable F was preoccupied with other duties, including the completely unnecessary task of taking an immediate statement from Mr. V, which had been arranged for her by Detective J.

In any event, it was clear from the Police Commissioner's Instructions that it was not her responsibility to complete the PAMF until a. bail determination was made. The result was that P waited nearly two hours in custody without a bail determination being made, and without any form of risk assessment carried out.

2. Why was P not properly supervised whilst he was in the holding dock?

The relevant portions of the Police Commissioner's Instruction state that the apprehending officer is responsible for the security and safety of the prisoner until such time as the custody officer assumes control, and that at no stage is someone in custody to be left unsupervised or in a position to cause harm to himself: par 11.02.

Apart from the general requirement in the Police Commissioner's Instruction that persons in custody be not left unsupervised, the holding docks of the kind in which P was confined presented their own problems in the form of eight hanging points.

In November 1994, correspondence had been sent to District Commanders that prisoners detained in such docks were to be kept under *'close and constant observation* pending their transfer to a more appropriate holding facility', a phrase which mirrors that in the Police Commissioner's Instruction dealing with prisoners at risk of self-harm. This instruction did not seem to have filtered down to those at ground level who were charged with the day to day use of the docks.

The layout of the Bellingen police station at the time was such that the dock was some distance from the computer where the documentary side of the charging process took place, which was in a front room. Hence anyone leaving the dock area to complete his or her computer tasks would not have the dock in view.

During her oral evidence, Senior Constable F said that she had seen paragraph 11.02. She conceded that this meant 'ensure that no such person is left unsupervised', meaning thereby 'one on one', 'observe at all costs and don't leave'. She said, however, that the reality of day to day policing made this impossible. However, later in her evidence, in answer to a question which invited the same response, she said she 'could have done' (that is, supervised him), by which I infer she meant that, with the benefit of hindsight, she could have left her other non-urgent tasks and maintained face to face supervision. In a COPS entry she filled out later, she said that she checked on him every 15 minutes, because 'you have to put a time in'. She didn't know why she put that because it was not correct. In fact she said she checked on him regularly and frequently, every few minutes, which the Coroner accepted.

Although Inspector L pointed out some inherent ambiguity in the term 'unsupervised', the reality of the situation in this instance was that for whatever reason the constancy of supervision was not maintained, with the result that P was presented with the opportunity to take his own life.

Under the circumstances, the Coroner found it difficult to be critical of Senior Constable F. In many respects, she is an innocent victim of the events of 15 April 1998. She was in bed when she was called back to duty following the 000 call about a fight at the front of the police station. The events which had occurred at the hotel and along the street were none of her making, but she was presented with the legacy of it.

She was asked to perform entirely non-urgent tasks such as the taking of a statement from Mr. V, and while she was doing so, was obliged to close the police station because of other distractions. According to Sergeant R, she had done all she was required to do in relation to the records of the deceased, because the risk assessment which formed part of the PAMF was not required to be completed until a formal decision had been made as to whether P was to remain in custody, and this was the responsibility of the arresting officers.

The procedures she was dealing with under the Crimes Amendment (Detention After Arrest) Act were new. She had not had occasion to utilise them before, but she fulfilled her obligation to promptly seek the appointment of herself as Custody Manager from the Coffs Harbour Local Area Command. She knew P, and despite his volatile temperament, her method of dealing with him was such that she was able to exercise a calming influence upon him. She had been able to lay the foundation for a rapport of sorts between the two. In her dealings with him, she treated him with respect.

3. The holding dock, and other like it, had eight hanging points

In his submission, Mr. B set out a useful chronology concerning the hanging docks, their inherent problems, and a distinct lack of action over the years to rectify those problems, which is reproduced below.

DATE	EVENT
26 August, 1994	State executive group endorses a program to review and rationalise all prisoner holding facilities
August -Nov. 1994	The newly installed docks are inspected and found not to comply with the requirements of the RCIADIC. The design included 8 hanging points
November 1994	Correspondence sent to District Commanders advising that prisoners detained in enclosed docks were to be kept under *"close and constant observation pending their transfer to a more appropriate holding facility"*
25 June 1996	Inspector W forwards a quote for repairs which would eliminate the hanging points
13 August 1996	Note by Inspector W:

"The problem is not difficult to fix., more space at the bottom, eliminate the hanging points at the top and the problem is resolved"

13 September 1996 Inspector W communicates with the Commander of the Royal Commission Implementation Unit:

"The major problem is potential deaths in custody because the "Docks" installed in Police Stations around the State have a design fault"

19 November 1996 Memo from Chief Superintendent W2 to Det Inspector O (reproduced below)

22 July 1997 Findings of the State Coroner in 2315/96

23 February 1998 Memo to Director Properties from Commander Northern:-

"Stations listed hereunder have Lexan enclosed docks which need modifications (enclosing openings at top and door sleeve) to bring the docks to the Police Service approved standard. Your urgent attention to this issue in the interests of duty of care and officer safety, would be appreciated"

Following this incident, modifications to the dock at Bellingen were completed on 10 July 1998, it is said 'as part of the state-wide modification and update program managed and funded by Property Services'. The modifications comprised eliminating the top ventilation opening and minimising the gaps between the top and sides of the door. Alternate ventilation was provided with the installation of the perforated metal in the ceiling of the dock. These modification were at a cost of some $7,735. In addition, surveillance cameras were placed at ceiling level at either end of the charge room, an extension speaker and volume control was installed to allow monitoring of police radio from the charge desk and air conditioning was installed at a total cost of $20, 243, including the cost of modifications to the dock.

In other words, the problem at Bellingen has been rectified. However, throughout the State there are still some 102 of the 162 category C stations whose docks await modification. (Category C stations are those where prisoners are detained for short periods during processing and charging, or pending transfer to another station, or while held for court purposes. Prisoners should not be detained for a period in excess of two hours at a Category C station unless engaged in that day's court process). Bellingen is a category C station.

The Coroner said that the police service had chosen to address this problem by correspondence and memoranda by glossing over the problem, and reiterating the need for 'constant supervision'. Thus the correspondence addressed to District Commanders in November 1994, advised that prisoners detained in enclosed docks were to be kept under *'close and constant observation'*.

Two years later, on 19 November 1996, Chief Superintendent W wrote:

"The glazed docks were approved in 1994 by the Minister with full knowledge that all hanging points had not been eliminated. However, the

docks were approved in accordance with Commissioner's Instruction No 155, which states that prisoners must be *totally supervised* before being placed in a cell. In accordance with these instructions, the dock was designed to secure prisoners during the charging process, or whilst awaiting transport to a major holding centre on the basis they would be *under constant supervision*.

While the new style docks are gradually being installed a preferable alternative due to a perceived minimised risk of hanging, there is no current active program underway to replace all docks (1994 design) due to the *overriding supervisory requirements detained in these docks*". (My italics)

The problem is that these directions and reminders do not appear to have filtered down to where it matters most, and that is to those in the field. There is currently underway a program to replace the defective docks. However, the problem of communicating the requirement for personal observation of persons detained in the holding docks to those in the field remains.

Inspector C was given the task of preparing an 'easily accessible and understandable document dealing with custody'. The draft of that document which will become part of CRIME is annexed to Exhibit 31. Additional guidelines have been included. 'These deal with the need for police to maintain constant face to face observation of a person in custody (even if that person is in a dock) until that person is released or until the level of risk has been assessed, an inspection frequency determined and the person placed in an observation cell or other suitable cell'.

The problem remains that with the docks in question and their inherent dangers, nothing less than constant face-to-face supervision will suffice. In this regard the Coroner said that he agreed with the submission of Counsel assisting that 'in view of the responsibility of the Police service for creating the danger (i.e. a holding dock with identified points) and the level of ignorance revealed by the evidence as to the existence and dangers of the unmodified docks it is insufficient to have yet another document circulating requiring face to face observation.'

Possible draft recommendations prepared by Mr. W, Counsel for the NSW Police Service, and circulated among those present were handed to me which include a requirement that each unmodified charge dock be labelled with a warning that 'continuous face to face observation' is required. The Coroner agreed that this was an appropriate suggestion and he intended to adopt the recommendations that had been prepared, subject to some modification to make them even more explicit.

The Coroner said that it was trite to say that 'continuous face to face observation' means just that, and if it is necessary to close the door of the police station and to turn on the answering machine to achieve that end, then so be it. On behalf of his client, Mr. W did point out that whilst progress in modifying these docks had been slow, there were a great number of projects competing for priority for limited resources. Further, that there were no deaths in custody during 1999 and thus far none in 2000. There was still work to be done, he said, but the work carried out thus far has had an impact.

3. The education of police officers on the issues arising in this inquest

The Coroner said that Police Commissioner's Instruction 155 contained just about all the answers by way of prevention to events as they unfolded on 15 April 1998. Yet the police officers involved in this case were quite ignorant of its contents. The Manual sat on the mantle piece in volumes at the Coffs Harbour and Bellingen Police Stations but was only consulted as required.

Senior Constable F had been told that violent people were a suicide risk but couldn't remember when. She had never undertaken a risk assessment before and regarded this as just another form you filled in. She had seen par 11.02 of Police Commissioner's Instruction 155 to the effect that people in custody should not be left unsupervised or in a position to cause harm to themselves. Whilst she interpreted this as 'observe at all costs and don't leave', she said the reality of day-to-day policing did not allow that to happen. However, she later said that she 'could have' (supervised him).

During his record of interview, Detective A complained about the Department bringing in changes to the rules about custody procedures overnight and telling the officers in the field nothing about it and giving them no appropriate training. From the witness box, Sergeant R concurred in this assessment. Senior Constable F also said that the Charge Management system was 'totally new ' to her, that she hadn't filled in these forms before and 'didn't have a clue how to do it'.

There are qualifications that need to be made concerning these comments. In the first place, the computerised PAMF was only a reformulation of the documentation that had to be filled out manually before the advent of on-line charging. Secondly, when the Crimes (Detention After Arrest) legislation took effect on 9 February 1998, a notation to that effect appeared in the Police Service Weekly. It was quite general, but contained a note about where to go for information concerning the new laws: see your EDO; read the new CRIME Code of Practice; speak to your local police prosecutor or region prosecuting services; and 'for custody management & COPs charge management assistance' (sic).

Police Commissioner's Instruction 155 was withdrawn on 1 January 1999 and replaced by the Police Service handbook and CRIME. Those issues that relate to custody procedures are now to be incorporated into the one document

Further, the Goulburn Police Academy now conducts a number of courses for the education of serving police officers, including Safe Custody Courses. A Custody Manager's workshop was formulated in response to the enactment of the Crimes Amendment (Detention after Arrest) Act and the Crimes (Detention After Arrest) Regulations that took effect from 9 February 1998, not very long before the tragic events that we have considered in this inquest.

The original aim of the Safe Custody course, which commenced in 1994, was the general safety, security and well being of persons in custody within the cell complex in a police station. Its scope is currently under review. Whilst the Safe Custody Course today deals with such things as the prevention and assessment of suicide risk, Inspector B said that police officers are not mental health professionals. They are simply given the indicators.

"The Safe Custody Course is delivered in the field, dependent on a need being identified within a Local Area and or region and the receipt of a request from that area seeking the conduct of the course". (Par 10). The Custody Manager's Workshop and the Safe Custody Course have been amalgamated since August 1999, the workshop being conducted on the first day of the Safe Custody Course.

On 18 March 1998, Senior Constable F received training in relation to the roles and responsibilities of Custody managers as part of the Investigators Course she was undergoing. This course contained an overview of Part 10A but she said she couldn't remember anything about it. After the events that brought about this inquest, she underwent the Safe Custody Course which she completed on 26 February 1999.

Similarly, Senior Constable J is shown as having attended a course after these events on the Crimes (Detention After Arrest) legislation on 25 May 1998, but said that he had scant recollection of it. Senior Constable A also attended the same course on 25 May 1998, and the Custody Manager's Workshop that he said he benefited from.

The Court was provided with details of the numbers of officers who had completed the Safe Custody Course and the Custody Manager's workshop. However, the Coroner noted that there was apparently reluctance on the part of some officers to attend the course, as they have no interest in that aspect of policing.

This raised an issue concerning the continuing education of police officers. As was evident in this case, police officers do not necessarily read everything that is accessible to them they have to. The Coroner said that when important changes take place such as the Detention After Arrest legislation, it would obviously be desirable for a series of workshops to take place across the state that all police officers are obliged to attend explaining the operation of those changes. Police officers are much more likely to remember something that unfolds before them in a workshop rather than something to which their attention is drawn in a booklet which they may never read until it is too late. He said so notwithstanding the difficulties that Senior Constables J and F seem to have in remembering that they attended these courses.

Further, the Coroner ventured the view that at some stage of their career all officers should do the Safe Custody Course (as distinct from the Custody Manager's Course) where such things as the 'fairly obvious warning signs' evident in this case, and safe custody procedures generally can be the subject of explanation and comment. In other words, attendance at such a course should not need to depend on a request from the Local Area Commander. Whilst an officer working on the beat may not necessarily need to know as much as an officer who is restricted to the station, his experience with a particular prisoner may be something he can bring to the notice of the custody officer for the purpose of risk assessment. Further, when a prisoner is arrested, the duties of apprehending officer and custody officer dovetail, the one into the other.

Reasons for findings concerning P's death

The Coroner said he was satisfied that P died from hanging whilst in custody at the Bellingen Police Station on 15 April 1998. He reiterated that he was satisfied that he did so as a result of his own hand and that there was no outside intervention in the circumstances of his death.

There was speculation that P may not have intended to take his own life. He used his a torn up portion of his shirt to place around his neck, rather than his belt which was available to him. He was under the influence of alcohol and cannabis. He may have been doing what he did as a ruse to gain attention in order to be released from his confinement. Sergeant R said that many deaths by hanging are unintentional.

The Coroner was reluctant to make a finding of suicide unless there was cogent evidence to that effect. He intended to make a finding that P died by hanging self-inflicted. He did not intend to make a finding that he did so with the intention of taking his own life.

Finding

That [the deceased] died in the dock whilst in custody at the Bellingen Police station at about 5.00 pm on 15 April 1998 from hanging self-inflicted.

Recommendations

1. That the Commissioner of Police issues a direction to each Local Area Commander to identify those charge docks within their command which do not conform to the current NSW Police Service Building Code in that they contain hanging points.

2. At each such police station a set of Standard Operating Procedures be formulated to be posted in a prominent position in the charge dock area. Such Standard Operating Procedures should include as a requirement that any prisoner confined in the dock should be kept under continuous face-to-face observation.

3. Each charge dock identified in accordance with Recommendation 1 should be clearly labelled with a warning in a conspicuous place to the effect that "This dock does not conform to the current NSW Police Service Building Code in that it contains hanging points. Any prisoner confined in this dock should be kept under continuous face to face observation".

4. The list of police stations with unmodified docks which do not conform to the current NSW Police Service Building Code be drawn to the attention of those police undertaking the Safe Custody Course, together with the need for constant face to face supervision whilst prisoners are confined in those docks and the priority that such supervision should be given.

5. That consideration be given to making attendance at the Safe Custody Course a mandatory requirement of the continuing education of a police officer.

776 of 1998 **Male aged 39 years died on or about 18 April 1998 at Grafton Correctional Centre, Grafton. Finding handed down on 26 June 2000 at Grafton by John Abernethy, State Coroner**

The deceased, a 39-year-old male, prior to his incarceration resided with his defacto wife and her daughter, at Crane Street, Ballina. On the evening of 12 April, 1998 a neighbour visited the deceased and his partner. Both, she said, were affected by alcohol. At about 11 pm, the neighbour returned home. At about 1 am on 13 April, 1998 the deceased took his partner's daughter to the same neighbour's home and asked her to mind the daughter as he was going to kill himself. He then got into his car and drove off at high speed. He drove his car into a gutter and a stationary motor vehicle. On alighting from the car near the Ballina R.S.L. Club the deceased told a number of people that he had just killed his girlfriend and was intending to take his life. He was taken to Ballina Hospital and treated.

In the meantime, the neighbour had attended at the home of the deceased and his de facto and found the de facto seriously injured with knife wounds to the throat and stomach. She died en route to Lismore Base Hospital, at about 3.25 am. The deceased was placed under arrest at about 1.35 am at Ballina Hospital. A guard was placed on him.

Initially the deceased refused to talk to police but indicated that he wanted to die with words like "just put a bullet through me".

One eyewitness to the motor vehicle incident indicated that the deceased said that he had just killed his girlfriend and was trying to kill himself.

When the police tried to interview him more formally at about 4.20 am he said little other than making comments like "I'm not saying anything. You can put a bullet through me if you like. I should be dead. You're wearing a gun, just make it easy and shoot me in the head. I should try and grab your gun and then you would have to shoot me."

At about 7.20 am police arrived at the hospital and indicated to the deceased that his de facto had died. He was cautioned and charged with her murder. He appeared surprised and confused.

Various police watched the deceased carefully after he was discharged, in custody, from hospital. A Senior Constable who was the Custody Officer had him in charge on the morning of 13 April and he was kept under constant video surveillance whilst in the lexan dock. He was seen by a solicitor, and taken to an interview room for a short period. He complained of sickness in the stomach and asked to be allowed to lie down. He was taken to a cell and kept under video surveillance. At about 12.50 pm he was transferred to the Lismore Cell Complex. Whilst in his custody, the officer formed the opinion that the deceased was remorseful and angry with himself - and perhaps slightly depressed.

Sergeant of police at Ballina commenced the custody questionnaire and assessed the deceased as quiet but cooperative, appearing to be "quieter and reflective". He requested headache tablets.

At about 1.40 pm the deceased was transported to the Lismore Cell Complex at Lismore Police Station. The transporting officers made statements to the effect that he did not utter a word and appeared "despondent and withdrawn".

On the 13 April a female Senior Constable of Police was rostered for duty at the Lismore Cell Complex from 6 am to 6 pm. She received the prisoner at about 1.45 pm and noted him to be limping and with abrasions to his face, arm and leg. She updated the custody records and at about 2.05 pm, placed him in a cell. She observed him regularly and recorded her observations. He requested and was given a copy of the murder charge fact sheet. He received telephone call from a family member at about 5.30 pm. The Senior Constable worked again in the cell complex the next day, 14 April, between 6 am and 6 pm. Her shift was again uneventful and at about 9.20 am officers of the Department of Corrective Services arrived and removed the prisoner to the Grafton Correctional Centre. All relevant papers went with the prisoner, including the NSW Police Service Assessment Document. The female Constable stated that whilst in her custody, the deceased appeared depressed. She did not, however, consider him suicidal.

The Shift Supervisors at the Complex described the deceased as "calm" and "quite calm".

A Senior Prison Officer received the prisoner into the prison and was struck by the fact that he appeared "relaxed and normal, considering the seriousness of the charge against him". He took particular notice of the prisoner because he was in custody for a most serious offence. He deposed that he was "given no indication that the inmate was going to commit suicide."

A most competent and experienced Registered Nurse of the Corrections Health Service assessed the prisoner. She knew of his attempt to harm himself with his motor vehicle and formed the opinion that he was at risk of self-harm. Accordingly she recommended that he be placed "two out" until further order. He denied any intention to harm himself but was generally reluctant to answer questions. He did say that he did not care if he lived or died. The Registered Nurse formed the view that he was in fact future oriented as he was asking questions about bail and legal representation. She referred him to a General Practitioner, Psychologist (both of whom saw him before he died) and a psychiatrist.

The psychologist interviewed the prisoner at length but did not come to the opinion that he was likely to harm himself.

He was placed in Cell 13 of One Wing, two out with a young prisoner, "A" on the afternoon of 14 April 1998.

On 16 April 1998, a prison officer who attended with the Registered Nurse at his Corrections Health Service reception interview chaired a Classification Committee, along with a Social Worker and a Probation Officer. He was aware of the earlier intention of the deceased to harm himself and made the other committee members aware of it. At the meeting the deceased did not give any indication that he might be at risk. A recommendation was made that he be transferred to the Metropolitan Remand and Reception Centre, Silverwater.

Pending that transfer he continued to share a cell with prisoner "A". He told "A" of his intention to take his life, indicating to him that he missed his girl friend and wanted to "be with her again". "A" was very concerned but the deceased asked him to swear that he would tell no one.

In the early morning of 18 April 1998, the deceased hanged himself in his cell whilst "A" was asleep. "A" Awoke and raised the alarm.

The prisoner was cut down. An experienced Senior Prison Officer placed "A", who was extremely distressed, with a sweeper until a nurse could assist him. The officer also searched for a carotid and radial pulse but could not find one. Though firmly of the view he was dead he applied CPR for a short period of time.

He was censured by the Department of Corrective Services (a) for not continuing CPR until arrival of medical staff; and (b) for placing "A" with another prisoner rather than in a cell by himself. The State Coroner took the opinion that those infringements of the instructions to Prison Officers were of a minor nature in this particular case and warranted no further punishment. In fact, he said, in view of "A's" extreme distress it was understandable that he be placed with a caring prisoner in the short-term. He noted that his involvement in the finding of the prisoner and dealing with the death in custody had affected the Senior Prison Officer most adversely, and urged him to use the inquest process to get his own life and career back on track.

Whilst Prisoner "A" should obviously have told the authorities of the intention of the deceased to take his life, the State Coroner noted that he too had been affected by the death of his cell mate most adversely.

The State Coroner heard detailed evidence from a senior officer of the Department of Corrective Services. He noted that since this death uniformity of reception procedures has been brought to all Reception Centres. All centres now perform a further assessment by an appropriately trained officer of the Department of Corrective Services which complements the Assessments still carried out by Registered Nurses of the Corrections Health Service. Further, all Reception Centres have in place Risk Assessment or Risk Assessment and Intervention Teams to assist with "problem" prisoners. Generally there has been a strengthening of reception procedures aimed at reducing the risk of prisoners taking their own lives.

Finding

That [the deceased] died on 18 April 1998, in Cell 39 of One Wing, Grafton Correctional Centre, Grafton, by hanging, with the intention of taking his own life.

The death of the de facto of the prisoner

The State Coroner conducted the inquest into the death of the de facto of the prisoner at the same time. He found that she died of her injuries en route, by air ambulance to Lismore Base Hospital and returned a formal finding into her death in the following terms.

Finding

That [the deceased] died on 13 April 1998 near Lismore, of abdominal stab wound and incised wound of neck, inflicted on or about 13 April 1998 by a person since deceased.

856 of 1998

Male aged 22 year died on 22 April 1998 in Westmead Hospital. Finding handed down on 23 February 2000 at Glebe by John Abernethy, State Coroner

The deceased, T, a 22 year old Caucasian male unsentenced prisoner was received into the Metropolitan remand and Reception Centre, Silverwater (MRRC) on 18 April, 1998 from Liverpool Local Court. He had been charged with "steal motor vehicle". Though granted bail in a modest amount he could not find another person as an acceptable person and was thus held pending entry of bail. He had been in prison before and on this occasion chose to give both police and officers of the department of Corrective Services/Corrections Health Service a false name. At the time of his death the result of the taking of his fingerprint had not come to the attention of those responsible for his custody. The matter is relevant as his previous Corrections Health Service file contained relevant information in relation to the threat of suicide. It also gave details of drug usage and withdrawal.

The prisoner died on 22 April 1998 in Westmead Hospital following his hanging himself in his Cell, Number 53 of Darcy Pod One, MRRC on the night of 20 April 1998.

The State Coroner found that the NSW Police Service and the Department of Corrective Services/Corrections Health Service appropriately received the prisoner into the system. He went through a competent Welfare Assessment and Health Assessment. He was not considered to be at significant risk of suicide. Rather he was assessed as being anxious and depressed, as withdrawing from Heroin and Valium. He was referred to a psychologist and placed on a regimen to assist with his withdrawl from drugs. He was, pursuant to his health assessment placed in an observation cell on the night of 18 April 1998, with a review the next morning. On 19 April, he was reviewed by another registered nurse who recommended he be placed in normal discipline, but either "2, 3 or 4 our" on an ongoing basis. He was thus placed in Cell 53, Pod One (Darcy) on the morning of 19 April, 1980 with another young prisoner, M.

The deceased slashed his wrists in the early morning of 20 April 1998 in order to obtain either a cigarette of a light for one. He raised the alarm and was take to the Clinic where his superficial wounds were bandaged. He was given a cigarette by nursing staff, and placed in a safe cell for the rest of the night. He was returned to Cell 53 the next day after returning from Liverpool Local Court. He had given his cell mate no indication that he was going to slash his wrists.

On the morning of 20 April 1998 the deceased was transferred Liverpool Local Court where he undid his bandages and picked at his wounds, smearing blood over the walls of his cell. After an expedited court appearance he was returned by car to the MRRC. He had to be placed in a restraint so that there would not be further self-harm.

The Coroner was satisfied that up to the return of the prisoner to Silverwater the actions of all relevant officers of the Department of Corrective Services and the Corrections Health Service were appropriate. In fact the officers at the Liverpool Court Cell Complex deserve commendation for the manner in which they handled a most difficult young prisoner.

On the return of the Prisoner from Liverpool Local Court on 20 April 1998

There was a hand over between the Liverpool Court DCS officers and a Registered Nurse (K) on the return of the prisoner from Court. Whilst the nurse was orally briefed as to what had transpired at Liverpool, he may not have been told of relevant conversations occurring in the car on the way back for the MRRC whereby the prisoner announced that he "would not be returning to Liverpool (two days later)". Further, the officer in charge of the Liverpool Cell Complex telephoned a Registered Nurse at Silverwater that morning, describing the behaviour of the deceased, but that nurse probably did not pass this information on to Nurse K. Nurse K carried out an assessment of the prisoner who assured him that he wanted to go back to his normal cell and that he was not going to self harm. In front of the nurse he said the same thing to the Receiving Corrections Officer (P) on arrival at the Darcy Unit, Pod One.

The State Coroner found that the Registered Nurse (K) should not have authorised the removal of the prisoner from the safe cell to normal discipline without first obtaining the consent of a psychiatrist by telephone. He was also satisfied that the nurse was not aware of this requirement. On the evidence before him, however, the Coroner took the view that the decision of the nurse, on the information held by him was reasonable and further, a psychiatrist, briefed by a Registered Nurse would probably have authorised the removal to normal discipline.

The Coroner noted that the system of obtaining the consent of a psychiatrist was found not to be working satisfactorily and therefore altered by replacing it with assessment by a Risk Assessment Intervention Team (RAIT). RAIT Teams are made up of elements of the Departments of Corrective Services and Corrections Health Service and include a Registered Nurse, a Custodial Officer, a psychologist and/or a Drug and Alcohol Counsellor as may be pertinent to the individual case. He also noted the evidence of the Chief Executive Officer, Corrections Health Service, that the rate of suicides at the institution had dropped significantly since the implementation of the system. He stressed that for the RAI Team system to work effectively the Team should always have the most recent relevant data relating to the prisoner.

The State Coroner found that the deceased was not suffering from a mental illness but was depressed, anxious and agitated. He was withdrawing from drugs and had not obtained his freedom despite being eligible for bail. His prior acts of self harm were essentially attention seeking in nature. His behaviour was both impulsive and attention seeking.

He made the point, however, that the officers who returned the prisoner to the MRRC from Liverpool were seized of important information about the prisoner that was probably not received by the assessing registered nurse, K.

The prisoner wanted to leave the safe cell he was in to return to normal discipline. He made his wishes known to both the assessor and the gaoler. His decision to end his life was probably spontaneous and impulsive as had been his earlier decisions.

The attempt at Hanging on 20 April, 1998

The evidence disclosed that on the night the deceased hanged himself, the Cell Call Alarm was activated at 23.03.47. The Call went through a sequence of rings to Darcy Pod Station Office, then to Central Control, then back to Darcy a number of times. It was answered at the Pod Station at 23.06.58. The State Coroner made no diverse comment about the period involved. He was satisfied that the cell mate, M. made the call but some minutes later, after no reply was received went to the rear of the cell where he commenced to bang on the window in a bid to attract attention. It was while he was doing this that the alarm was answered. He did not hear the officer inquire as to the reason for the call. The Officer, on obtaining no response from the cell, cancelled the call. In the meantime, obtaining no assistance by banging on the cell window, M went to the cell door and commenced to yell out from that position. He was heard by officers in the pod who promptly attended, cut the prisoner down and commenced resuscitation. Medical Assistance quickly arrived and the deceased was transported to Hospital.

On the evidence it is likely that the officers attended the cell in response to M, at about 11.15 (2315). There was thus a period of some 12 minutes from the initial raising of the alarm to entry into the cell. The State Coroner found that that period of time amounted to "unacceptable delay" in answering an emergency. He made a recommendation pursuant to Section 22A Coroners Act 1980 relating to the Cell Call Alarm system at the institution.

Conclusion

In conclusion, the State Coroner noted the unusual nature of the inmate population of the Institution, and its high turnover of prisoners, most of whom had special needs.

He urged the Department of Corrective Services to review its protocols relating to the logging of calls. He made recommendations relating to the \reviewing of the Cell Call Alarm system, the prioritising of cell calls and the education of officers in the operation of the Cell Call Alarm system.

Finding

That [the deceased] died on 22 April, 1998 at Westmead Hospital, Westmead, of hypoxic encephalopathy due to hanging, when he hanged himself on the 20 April, 1998 in Cell 53, Darcy Pod One, Metropolitan Remand and Reception Centre, Silverwater, with the intention of taking his own life.

Recommendations

1. That the Department of Corrective Services analyses the evidence at inquest and considers my findings of fact in this case with a view to considering whether the Cell Call Alarm System which operates in the

Metropolitan Remand and Reception Centre can be improved so as to ensure that urgent use of a cell call alarm by a prisoner can be more promptly attended to.

2. That the Department of Corrective Services gives consideration to the prioritising of Cells housing the most at risk prisoners (who are not in safe cells) so that use of the Cell Call Alarm by one of those prisoners in such cells is prioritised.

3. That all relevant staff of the Department of Corrective Services be fully trained as to the way in which the Cell Call Alarm at the MRRC operates.

872 of 1998

Samoan male aged 20 years died on or about 1 May, 1998 at Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 7 July 2000 at Glebe by John Abernethy, State Coroner

The deceased gave no indication at all to either corrections staff or fellow inmates, one himself also a Samoan, of his intention to hang himself.

Corrective Services officers followed the correct procedures at the lock-in of the prisoner on the evening of 1 May 1998. He was discovered at 7.40 am on 2 May 1998, hanging from a sprinkler system by a cut bed sheet. He had left a brief note on a board in his cell. The State Coroner was satisfied that the deceased took his own life. All death in custody protocols were followed by both Police investigators and Corrective Services personnel.

On 26 March 1998 the prisoner was sentenced to a minimum term of imprisonment of six months, for the offence of "steal from the person." His sentence commenced on 6 March 1998. He was thus due for release on 5 September 1998. An additional term of two months was set. He was thus a sentenced prisoner at the time of his death but was also facing further charges that, if proved, may well have lengthened his sentence. He was also serving a sentence of one year, four months and eleven days by way of balance of parole.

As part of his reception assessment into the MR.RC, at 1.30 am on 17 March 1998, a Registered Nurse of the Corrections Health Service completed a "Reception Health Status Notification Form". (A large intake of prisoners on a given day means that reception staff must work until all have been processed). She initially found the prisoner not to be at risk of suicide, nor an acute risk of self-harm. She found him not to be inappropriately fearful or anxious about his imprisonment. The prisoner told her that he had not before committed impulsive or stress related acts of self harm or attempt at suicide; nor had he performed a planned suicide attempt.

Later the same day the prisoner was interviewed by a Welfare Officer of the Department of Corrective Services. This officer completed an inmate profile, dealing, inter alia, with psychological issues. Again the prisoner denied any self-harm suicide ideation and indicated he was coping with life in prison though a little "low". On checking other data, including the discharge summary in respect of his previous term of imprisonment, the assessor found that the prisoner had a history of self-harm and violent behaviour. He had

also been referred to a psychologist before. As a result, on 30 March 1998 a psychologist saw the prisoner. She found him to be bright and reactive, stable and adjusting to prison. She recommended psychological follow-up, mainly to address any violent behaviour and any behaviour that may be of future concern.

On 21 March 1998 the prisoner attempted to strike a senior corrections officer who was attempting to calm him. He was taken to Darcy Pod 3 and ordered to be segregated until 4 May 1998.

On 25 April 1998 the prisoner cut himself with a razor blade and was examined and treated appropriately. Old scars were noted and when the prisoner indicated that he was uncertain whether or not he would attempt self-harm again, he was lodged in a safe cell. (He had indicated that he harmed himself because relatives expected to visit had not done so.)

He was referred to the Crisis Intervention Team and was seen the next day. The State Coroner found his responses to questioning to be generally unreliable. The prisoner requested a male psychologist and again indicated that he might self-harm. He was returned to his safe cell.

The State Coroner found such safe cells to be used for prisoners manifesting acute behaviour only. They are Spartan and sterile, with no amenities - most prisoners do not want to be placed in them. Further, to place a prisoner in such a cell for a long period, would be cruel and inhumane he commented.

The next day the prisoner was re-interviewed by the Risk Intervention Team (consisting of a psychologist, a Registered Nurse and a corrections officer). The Coroner found the team to be comprised of very experienced personnel. The Team came to the unanimous view that the prisoner was not suicidal and in fact had no self-harm suicide ideation. It terminated his "at risk" status and referred the prisoner, at his request, to the Chaplaincy and recommended that he be assigned a Case Officer.

On 29 April, 1998 the prisoner was again seen by the Crisis Intervention Team on referral from corrections officers. He told the team he "went off" because he had been denied a telephone call and a TV Receiver. He presented as calm, denying any self-harm ideation and agreed to seek out staff if he felt like committing harm to himself.

The inmate took his life several days later.

The State Coroner found that all those who dealt with the prisoner acted appropriately and reasonably. He found that the deceased was never suffering a mental illness and that referral to a psychiatrist would not have been appropriate. Rather he was seen, over a short period, by 5-6 clinicians of various disciplines. None at any stage felt him at risk of suicide.

The Coroner found the prisoner's suicide to be either sudden and unexpected, or he had harboured an intention to take his life for some time, but successfully kept that intention from not only the professionals with whom he came into contact, but also his fellow inmates. He commented:-

"Sadly, it is very difficult to stop a prisoner from taking his own life if he chooses to do so. A deal of action has been taken to address cell safety but the Department has to walk a "tightrope" between draconian imprisonment and safe custody. I am satisfied that the Department, over the past few years at least, has been able to do that with the prisoners uppermost in its mind. ..... The Department is also very acutely aware of the concept of safe custody and liability in certain cases where there is no adequate safe custody. I can see nothing in this case where any officer of the Department of Corrective Services or the Corrections Health Service, or indeed those instrumentalities (themselves) warrant anything but the most minor criticism (perhaps in relation to not considering documentation relating to a previous incarceration - whilst this was not initially done, the checks in place ensured that such documentation was seen and acted on very early into the prisoner's sentence)".

Finding

That [the deceased] died on or about 1 May 1998 in Cell DO 23, Darcy Pod 4, Metropolitan Remand and Reception Centre, Silverwater, by hanging with the intention of taking his own life.

1719 of 1998

Male person aged 22 died on 24 August 1998 at Goulburn Correctional Centre, Goulburn. Finding handed down on 4 April 2000 at Glebe by John Abernethy, State Coroner

Circumstances of death

The deceased was an inmate at Goulbourn Correctional Centre after being transferred from MRRC Silverwater on 20 August 98. He was serving a sentence of approximately 1 year and 1 month for a break enter and steal. He was also on remand for an offence of malicious wounding.

At about 1.50pm on 24 August 1998, the deceased was in 7 yard when he was attacked by unknown persons. He received stab wounds to his neck and abdomen. He then fell between the tables under a shelter in the yard. At about 3.15pm a yard muster located the deceased.

Inquest

Advice has been received that persons have been charged with an indictable offence in relation to the death of H. In those circumstances the inquest was terminated under the provisions of Section 19 of the Coroner's Act, 1980.

2351 of 1998 **Male aged 39 years died on 20 November 1998 at Coffs Harbour. Finding handed down on 15 February 2000 at Coffs Harbour by John Abernethy, State Coroner**

Circumstances of Death

The deceased was shot by a serving member of the New South Wales Police Service, in his home at Coffs Harbour on the afternoon of 20 November, 1998. The firearm used was the police officer's service revolver, a .38 Calibre Smith & Wesson. He died of a gunshot wound to the chest.

The deceased, an alcoholic, had been drinking alcohol all day on the day of and the day before his death. On her return from work, the wife of the deceased found him reeling about the house. Arguments ensued and he commenced to damage matrimonial property including the front lounge room window. She fled to her next door neighbour's and telephoned Coffs Harbour Police Station saying in effect, "my husband is very drunk and is smashing things around the kitchen and becoming violent. I am afraid to go back into the house and am next door at.....". The Communications Operator at the police station created a CIDS document (Computerised Incident Dispatch System) and orally dispatched two officers to the same premises at Hull Place, Coffs Harbour (the next door neighbour's).

Senior Constable C, an officer of 9 years experience was the rostered driver of Coffs Harbour 15 whilst Senior Constable F, an officer of 19 years experience was the rostered observer. Senior Constable C was advised by another police officer, probably the Communications Operator, that no Domestic Violence Orders were in existence. Whilst the two police officers were en route, the wife, Mrs. M telephoned police again saying "I rang before, R is still going off next door, I can hear him smashing things." She was told police were on their way.

At about 5.27 pm police told VKG that they were going off air to attend to a "domestic". The Communications Operator did not carry out a COPS "identity" or "residence" check until after the incident. Nor did he warm VKG or the call out officers that he had not done these checks.

The next door neighbour, very concerned, telephoned other neighbours prior to arrival of police. A neighbour, Mr. L attended Mr. M's house and as he walked around to the rear of the house he saw the deceased with a knife in his hand. The deceased threw away the knife on seeing Mr. L. Mr. L could not pacify the deceased and returned to his own home saying to his wife "it is a matter for the police".

At 5.31 pm, less than four minutes after calling off air, Senior Constable C contacted VKG requesting an ambulance and a Duty Officer to Mr M's house as a person had been shot by police. In that time police walked to the neighbour's house and spoke to Mrs. M, walked to the rear of and into Mr. M's house, shooting Mr. M.

When police arrived at the neighbour's house Mrs. M told them that the deceased had a knife, that he had been drinking and that he'd probably "taken off up the back". She told them that he had been aggressive and smashing up

the house. She did not however (and the State Coroner made no criticism of her) tell police that when drunk, her husband had a real hatred of police and had less than six months earlier seriously assaulted a police officer. She stayed at her neighbour's whilst police went to her house. A few moments later she heard an angry voice say "back off' or "fuck off' and then she heard a shot. She went into her house and saw that her husband appeared to be dead. She assisted police (as a Registered Nurse) with resuscitation procedures pending arrival of the ambulance.

The State Coroner heard evidence over ten sitting days. He also attended a view of the subject premises and surrounding area.

The two police involved submitted to ERISP Records of Interview later that night and were separately involved in a "video walk through" the next day. They were promptly separated from each other prior to their ERISPS. The State Coroner was satisfied as to the essential truth of their versions which were corroborated in a number of different ways. He was satisfied that they did not collude to give their interrogators a version of events.

Senior Constable C knew that there were no Domestic Violence Orders in existence against Mr. M. He parked the police vehicle some distance from the residences, took his baton and a portable radio and walked with Senior Constable F to the neighbour's house in Hull Place. Both spoke to Mrs. M and there was no conflict in the various versions of what was said. Senior Constable C could see the smashed front lounge window. He also ascertained that Mr. M had an assault charge against his wife pending (he had seriously assaulted her earlier in the year). Senior Constable C made the decision to check that the house was secure and moved to its rear, followed by Senior Constable F. He could see nobody inside the house. On reaching the open rear door he stated that he called out "it's the police" but got no response. He entered the premises via the open rear door and saw that there was nobody in the kitchen, living room or lounge. He held his baton in his right hand and moved up a small hallway, checking the toilet/bathroom and a spare bedroom. He looked into the master bedroom and saw a male standing at the window facing away from him. He called to the male "mate, can you just come out here a minute?" The male turned around and he saw a knife in his hand. He twice called upon the male (Mr. M) to put the knife down but the male "came at him". He backed down the hall and to his left towards the back door, the deceased charging and "roaring" forward. He was deciding whether to draw his service weapon or his OC (Oleocapsicum) spray when he saw the male change direction and head towards where he knew Senior Constable F had been when he commenced to walk up the hall. He was holding up a silver blade. He went to draw his firearm and heard a single shot. He saw Mr. M. fall to the floor, a meat cleaver falling to the ground. (Mr. M after throwing the knife away on recognising Mr. L, earlier, had obtained the cleaver from a kitchen drawer on re-entering the house). He (Senior Constable C) called for an ambulance and Duty Officer and assisted with CPR. He recalled Senior Constable F being near the TV in the lounge room when the firearm was discharged, and that the deceased had been charging towards him when the shot was fired. Senior Constable C told interrogating police that he assumed that the deceased may have been in the house when

he entered, but that he entered it to ensure that he was not there. He was in fear of his safety - of being stabbed, and his first thought was to create space between himself and the deceased.

Senior Constable F's version to police was similar. He heard Senior Constable C say "put the knife down, put the knife down', so drew his service revolver, positioning it in the "ready" position. On entering the house he searched behind a kitchen bench and then positioned himself in the middle of the living area. He had a route of escape, barring the unexpected, by either the front or back door. He told police that he saw Senior Constable C back away around the corner of the hall and exit through the rear door of the premises, and that the deceased then "lunged or charged at me with a meat cleaver positioned above his head. I attempted to retreat and rushed backwards, colliding with a flower stand which caused me to become off balance. The deceased still armed with the cleaver, attempted to thrust the blade down towards me. On realising I had nowhere else to go I had no option but to fire a shot which struck the left side of the deceased chest causing him to fall.... to the left onto the floor....."

Senior Constable F estimated that Senior Constable C was 5 - 6 metres from him when he heard "put the knife down" and the deceased was about 3 metres from him when he began to lunge at him. He fired the shot from about one metre, in real fear that he was going to be cut by the cleaver. At the time he fired he felt that he had no alternative available to him, and would probably have been struck in the chest had he not fired. He feared he may have been killed.

The State Coroner was satisfied that neither police officer had had prior dealings with the deceased.

Issues

The family of the deceased were initially very critical of police and raised a number of issues, all of which were dealt with at inquest. Such issues were: "Why did police enter the house when told the deceased was armed? Why weren't they prepared after entering the house? Why did the subsequent shooting occur? Why wasn't a siege declared? Why weren't batons or spray used? One member of the family feared a vendetta against his brother and raised the issue of whether the deceased had had previous altercations with the officers involved. The family also raised the issue of "police investigating police", and a lack of knowledge of officers of police "policies".

The State Coroner was satisfied that not only had there never been altercations between the two police officers and Mr. M, but that another constable who handled the earlier assault on Mrs. M had dealt with Mr. M in a most professional way, actually assisting the couple to attend to an issue of bail.

The State Coroner found that following the earlier assault in July 1998, Mr. M fled to Queensland where he was arrested at Warwick. At Warwick he seriously assaulted a female police officer, breaking her nose, and was sentenced to four months imprisonment. Senior Constables C and F did not know of this assault, nor of the pending assault allegation against Mrs. M.

The more important issues are highlighted below.

Police Operation protocols - forming a "shooting team"

The Coroner indicated that he felt that it was still appropriate that police investigated their own in circumstances like this but that where there is a shooting of a civilian by police the investigation team ought to be headed by an experienced Commissioned Officer - a detective with homicide investigation experience. The Coroner was satisfied that protocols developed by the NSW Police Service and the State Coroner as to the investigation of such matters were put in place on this occasion.

He noted that in rural parts of the State it may take some hours to assemble an investigation team. He therefore accepted that a Detective Sergeant of Police (G) (from another Local Area Command but not part of the "shooting team") could conduct the interrogation of the two police officers prior to arrival of the actual investigators, headed by Detective Sergeant T. In this case, therefore, the interrogation amounted to a "preliminary" interrogation. He commented:

> "Whilst I can see the reason for the preliminary nature of the interview in this case, if that is going to be done then there must be very detailed discussions between the interrogators and the investigators, so that the ultimate product is complete".

That was not done in this case and for that reason several questions, very relevant to the actions of the police, were never asked (what discussions, if any, occurred between police prior to entry; why enter the premises; was a plan of entry discussed?). These deficiencies in the interrogations were not noticed by either the reviewing officer or the Internal Affairs Consultant and had to be examined for the first time at inquest.

Suicide by "cop"

The State Coroner was not satisfied, on the evidence before him, that the deceased came at the armed officer with the intention of forcing him to use his firearm.

Prompt separation of the police officers involved

The State Coroner found that police had been promptly separated at the scene and transferred separately back to the police station. There their separation continued to the extent that they did not discuss the shooting. He was satisfied that though at one stage they were placed together in the meal room and advised to write versions of the incident in their official note books, they did not there speak to each other about the shooting. He commented:-

> "This is not a matter for a Recommendation (Section 22A, Coroners Act 1980). The protocol is clear. The police involved must always be physically separated as soon as possible and kept apart until they have been separately interrogated. All police who are likely to become part of a "shooting team" in the future must be reminded of the importance of this protocol."

Constable S and his late inquiry via the COPS System

The Coroner found it to be probable that Senior Constable C was told that there was no Domestic Violence Order in existence by the Communications Controller, Constable S, who in turn was probably told that that was the case by Mrs. M when she first telephoned for assistance. He also found that Senior Constable C also assumed, reasonably, that "person" and "location" checks had been carried out. In fact they were not carried out until some fifteen minutes had elapsed after the reporting of the incident. Constable S, a poor witness had no recollection of the circumstances as to how he came to carry out the checks after the event, nor why he did so at that time rather than earlier. Notwithstanding this failure, the State Coroner was satisfied that the failure to do so had little impact on the incident as such checks would only have shown up minor offences against police. That being so, the decision to enter the premises by Constable C would probably not have altered.

The State Coroner noted that the Queensland antecedents of the deceased showed most serious recent entries of "assault police", one of which led to a term of imprisonment. He recommended therefore, that consideration be given to installation of a system whereby all Australian Police Services might be informed of such offences so that warnings could be placed on each computerised information system.

The Evidence of Dr. P

Dr. P, a highly qualified and very experienced forensic pharmacologist gave evidence that the blood alcohol concentration of the deceased (0.215 g/100 ml blood) would have caused significant impairment of cognitive and motor functions. She said that the deceased would probably have had both a "chronic" and "acute" tolerance to alcohol, possibly resulting in his not appearing as affected to an observer as a non-tolerant drinker. She said that a level of 0.215 will generally result in impairment of balance, co-ordination, judgment, decision and (significantly) ability to recognise a dangerous situation. She said it will usually increase aggression and risk-taking behaviour and will also alter mood. Dr. P concluded her evidence by stating that she would expect the deceased to be capable of carrying out aggressive and threatening actions and to have been aware of those actions despite his impairment.

The State Coroner accepted her evidence and was satisfied that Mr. M. knew what he was doing when he came at police with a meat cleaver (in the same way that he knew what he was doing when he threw a knife away on recognising a harmless neighbour), even though he may not have fully appreciated the danger that accompanied his latter action.

Hollow Point Ammunition

The State Coroner accepted that the philosophy taught to all NSW police officers is that the use of a firearm is only as a last resort. Police officers therefore, may only use their side arms when it is believed that either the life of the shooting officer or another person's life is in imminent danger of death or serious injury. The rationale behind the use of hollow point ammunition is based upon the fact that the bullet is designed to expand on entry into, and

come to rest within the body of the subject, thereby reducing the chance of accidental death/injury to any person other than a person has in fact been shot in circumstances of last resort. For example, such accidental death/injury might occur by the bullet exiting the subject's body and hitting someone else; or the bullet might not in fact disable the subject. He therefore accepted that the use of hollow point ammunition is an appropriate tool for law enforcement purposes provided the weapon is used as a last resort.

The State Coroner found it also to be appropriate to teach police to aim for the "centre body mass".

O.C. Spray

The Coroner found that on the evidence before him, neither a baton, nor O.C (Oleocapsicum) spray would have been an appropriate weapon against the attack of Mr. M.

He found O.C. Spray, nevertheless, to be an important addition to the "non-lethal" armoury of the modern police officer. He found there to be some confusion as to the circumstances in which the spray should be carried and suggested that the NSW. Police Service ensures that all officers know precisely when the spray must be carried.

Release of excerpts of the psychology file of Senior Constable F

During the inquest, and over objection from Counsel for the NSW Police Service, the State Coroner made the decision to have tendered as an exhibit, excerpts from the psychology file of Senior Constable F. The excerpts contained conversations between F and his psychologist about the circumstances by which the police officers entered the subject premises. He took the view that there was a real forensic reason for taking the step (the investigators had not canvassed those circumstances in their interrogations of either officer).

The officer himself, Constable F did not object to the tender, thus waiving any privilege which existed.

The . State Coroner stressed that the use of such material at inquest must not be seen as in some way creating a precedent. He made a suppression order in respect of the data tendered.

Mr. M

The . State Coroner, on hearing the evidence found that, unknown to the police involved, the deceased was a person whose personality radically changed with alcohol so that sometimes he would become violent to others. He had in the past been extremely violent to his wife and another female. According to a treating psychiatrist he had a potential for violence and suicide. He had a deep seated and very real hatred of police and had only months earlier been gaoled for a most serious assault on a female police officer. Mr. M. had expressed his dislike of police to others. This propensity for such hatred and violence only surfaced when he became drunk.

He found that on the evening of his death, Mr. M. was in a violent, aggressive and unreasonable mood, self induced by alcohol. He had damaged property, armed himself with a knife, and then a meat cleaver. He had frightened his wife to the extent that she sought refuge with a neighbour.

On the night, the deceased became extremely dangerous to any police officer who might have gone near him. The situation was of his making. Significantly, he did not damage property with either the knife or the cleaver. He threw the knife away on recognising a neighbour, re-entered the house and armed himself with the meat cleaver.

The Coroner was satisfied from this evidence that he did so to await the arrival of police on his premises, and that his general purpose in arming himself was to harm/threaten to harm others, or perhaps to harm himself He was twice ordered to put down his weapon and chose to ignore that order. The Coroner found that his affectation by alcohol had little bearing on the matter in view of his earlier recent action of discarding the knife on recognising a neighbour, and in view of the evidence of Dr. P.

Mr. M. chased Senior Constable C from the area of the bedroom and hall, and on seeing Senior Constable F, who had drawn his firearm, rushed at him with the meat cleaver raised, leaving Senior Constable F no option but to fire his weapon in his own defence.

The Conversation between police and Mrs. M, and the circumstances in which police entered Mr M's house

The conversation between Mrs. M and police was not in dispute, however, in the witness box, Mrs. M. told the court that she thought carefully about what she was going to tell the police on their arrival. She said that the police left her presence before she could tell them about her husband's hatred of police and propensity for violence when drunk.

The State Coroner was satisfied that Senior Constable C, who took the decision to enter the premises, felt that he had learned all he needed to from Mrs. M to enable him to do so. He did leave her presence quite abruptly and Senior Constable F followed him, making no real effort to have him stop to discuss the matter further before entry. The Coroner was of the opinion, on the evidence before him that Senior Constable F did not want to enter the premises but did not make his position clear to Senior Constable C. Indeed, he followed C into the house and whilst in there, carried out his duties according to the appropriate principles of policing in such circumstances (providing "back up" and cover for the first officer).

Did police use unnecessary haste in leaving Mrs. M. and entering the house?

The State Coroner heard a deal of expert evidence from senior police officers. He became satisfied that Senior Constable C's decision to enter the house to secure it and examine any damage was a sound one in the circumstances of what he knew of the situation. Once in the house, he behaved appropriately in searching it. He felt, for a number of reasons that it was imperative that police act quickly, and the Coroner accepted his evidence.

The State Coroner agreed with Counsel for the family, and with the evidence of senior police officers that there ought to have been a brief discussion between the two officers about precisely what they were going to do and how they were going to do it. He was of the opinion, however, that it is unlikely, in all the circumstances that such a discussion would have made a difference to the situation, as the house really had to be secured.

The Coroner commented that had Senior Constable F been opposed to the decision to enter the house, he should have made his position very clear to his partner.

The Coroner found that there were cogent reasons for entering the house reasonably promptly, particularly as the deceased was thought to be in possession of an edged weapon, and had earlier that year assaulted his wife.

Conclusion

The New South Wales State Coroner was satisfied that Mr. M was shot by police as described by them and that the body was not moved after the shooting. He found that no police officer interfered with the body, beyond rendering first aid.

He found that Senior Constable C acted appropriately and in accordance with police procedures and training. Reluctant though he may have been to enter the house, Senior Constable F, too, acted appropriately as the "back up" officer, placing himself in a position where he could "cover" his partner and escape, barring the unexpected.

The State Coroner accepted that whilst it was arguable that back up might have been called, this case was seen by experienced officers as truly border line. In any event, police still had to enter the premises as soon as possible. The modest size of the premises would have made it unduly hazardous for more than two officers to have entered.

The Coroner accepted the evidence of Senior Constable C, that he entered and searched with care; that he made sure that he was "covered" by F; that he continually listened, looked and thought - assessed and reassessed the situation. He found those to be the actions of a police officer carrying out a hazardous duty professionally and in accordance with public expectations.

He commended the officer for the manner in which he undertook these responsibilities.

The State Coroner also accepted that the other officer placed himself correctly in the house and had no option but to fire at the deceased when he did; that his shooting of the deceased was in self defence and in circumstances where there was an immediate threat to his own life.

Finding

That [the deceased] died on 20 November, 1998 at ... Hull Close, Coffs Harbour, of a gunshot wound to the chest inflicted then and there by F, a member of the New South Wales Police Service, in the execution of his duty, such death being a justifiable homicide.

Recommendations

1. That the New South Wales Police Service requests the National Exchange of Police Information (NEPI) to consider the feasibility of disseminating information concerning serious crimes against police officers in any jurisdiction, on a nationwide basis with the view to enabling all police services to place a warning on their computerised information systems.

2. That any officer generating a CIDS (Computerised Incident Dispatch System) document relating to a "domestic violence" call out, immediately carries out all relevant inquiries, including COPS inquiries as to "person", "residence", any warnings, "CNI" and "domestic violence orders", and communicates his or her findings to the police officers engaged in the call out. If for some reason such inquiries cannot be carried out, VKG and the officers involved must be informed.

3. That the New South Wales Police Service Considers a review of the NSW Police Service Handbook (D.17 Domestic Violence) with a view to removing the material set out therein and directing users of the Handbook to the manual entitled "Domestic Violence Procedures and Training Manual."

2423 of 1998

Male of 34 years died on 1 December 1998 at Goulburn Base Hospital. The finding was handed down on 25 August 2000 at Goulburn, by John Abernethy, State Coroner

This 34-year-old Caucasian male prisoner attempted to hang himself in his Cell, Number 10, of 2 Unit, Goulburn Correctional Centre, Goulburn on the night of 29 November 1998. He died in the Goulburn Base Hospital on 1 December 1998.

Whilst the prisoner had a history of self-harm prior to entering the Goulburn Correctional Centre on this occasion, he was initially promptly assessed by a Registered Nurse of the Corrections Health Service. Following an attempt at self-harm on 21 September 1998 he was placed in a "safe cell" and assessed by a Crisis Intervention Team. The Team assessed him as being able to return to normal discipline, two out. The deceased entered into a contract not to harm himself. The State Coroner was satisfied that the placement of the deceased, two out and on that contract was appropriate.

Facts

The deceased had been sharing a cell with another prisoner since September 1998, though he and the prisoner he was with on the night he attempted to hang himself did not come together until morning of 29 November. There is nothing to indicate that the prisoner had in any way indicated either to his cellmate or to officers that he might take his life.

According to his cellmate, the deceased seemed "fine, not upset by anything". The cellmate went to bed at about 7.30 pm. Later he woke to go to the toilet and found the prisoner hanging. He pressed the cell call alarm and prison officers arrived "after a short time". The cellmate was very distressed when correctional officers arrived at the cell.

A correctional officer was working in the Control Room of the prison at the time of the "knock-up". At 11.03 or 11.05 pm, she received the cell call alarm signal (the Control Room Log shows 11.08 (see below). She logged the alarm call and notified the "Night Senior". She also notified the ambulance to attend on the instruction of the more junior of the two officers who attended the Wing and Cell. She did this at 11.15. The Coroner was satisfied that the ambulance was called as soon as the officer was instructed to do so. She logged all times from a video clock in the control room.

The Senior Correctional Officer in charge of the institution at that time of night (night senior), and a Correctional Officer were let into 2 Unit by a third Correctional Officer who, according to procedure, locked them into the Wing. The night senior kept a log in respect of the incident. She confirms receiving advice of the "knock-up" but at 11.10pm. According to her log she opened the Cell door at 11.19, and at 11.22 instructed the other officer to call for an ambulance, The Governor, The Deputy Governor, Police and the Emergency Unit. The ambulance "patient report" shows that the ambulance was called at 23.18. In those circumstances the Coroner found the Control Room Log to be the more accurate document.

The Night Senior had seen the prisoner earlier in her shift, when she attended him with a Registered Nurse. At the time he and the nurse were joking - he certainly did not appear depressed.

So at approximately 11.10 pm the two officers attended the cell of the prisoner (at that time of night the wings have been vacated by Wing staff and the prison given over to the Night Senior's team of approximately eight officers. They found the cellmate distressed and the deceased hanging at the rear of the cell by a bed sheet tied to a window bar. He appeared to both officers to be dead. With some difficulty the officers cut the deceased down. The more junior officer attempted to find a pulse, heartbeat or sign of life. He found the prisoner cold to the touch and clammy. The Night Senior removed the other prisoner from the cell and spent much of her time with him. Both were very distressed.

Neither officer attempted Cardio Pulmonary Resuscitation. Their inaction was contrary to "Instructions to Prison Officers." Instruction 13.2 deals with Deaths in Custody. At 13.2.1.2 the Instruction to the Senior Wing Officer is, inter alia:

"5) i) Immediately attend the incident scene;

ii) Ensure that the discovering officer has taken appropriate action (ie is attempting resuscitation ..... .)"

The Night Senior was disciplined by the Department of Corrective Services for not ensuring that the other officer "took appropriate action" and applied first aid. Had she done so she would have ascertained that he was virtually untrained and in those circumstances would have had to take over the task herself. The officer accepted that the discipline was appropriate. In other respects the instructions were adequately carried out.

The State Coroner commented:-

"Whilst this is a serious omission I am satisfied that prompt application of CPR is unlikely to have altered the outcome. On the timings I outlined earlier, the alarm was not raised until either 11.03 or 11.05. The prisoner was already hanging when his cellmate awoke and raised the alarm. I have no way of knowing how long he had been in that position, but if timing is taken from 11.05, or even 11.08, it appears that the officers did not have him cut down until about 11.15. That being so, on the medical evidence before me it is highly unlikely that he would have lived. Even if he had lived he would have suffered severe neurological damage. A pulse was found by ambulance officers after they commenced CPR. It was maintained by them with difficulty. On arrival at Goulburn Base Hospital, a pulse was again found but the prisoner was in a deep come (Glasgow Coma Scale: 3)."

He found, in subjective terms that any omission by the Senior Officer probably did not contribute to the death of the prisoner. In human terms, both officers were extremely upset by what they saw and dealt with the problem as best they were able. The Coroner found that there was virtually no communication between the officers and he stressed the need for communication in circumstances such as the officers found themselves.

The State Coroner also criticised the Department of Corrective Services for the fact that one of its officers was not trained to perform CPR.

He found that the prisoner died at 5.20 am on 1 December 1998, at Goulburn Base Hospital.

Issues

1. Hanging Points

The State Coroner found that the ease with which the prisoner hanged himself whilst his cellmate was sleeping, most disturbing. However he referred to the remarks he had made in Inquest 463 of 2000 (Cessnock - 11 August, 2000). He was prepared to accept that the Department is addressing the problem of hanging points as best it can with the resources available.

2. Statements by Corrective Services Staff, especially those involved in a Death in Custody

The Coroner heard evidence of a "culture" of "keep it simple stupid" in relation to the preparation of such statements, and of the remaking of such statements by direction of more senior officers. Whilst that was not suggested in the instant case it was nevertheless of concern generally. He was of the opinion that such officers ought to be promptly separated and the making of such statements, supervised by a very senior officer, as in fact occurred in this instance.

3. First aid training of Correctional Officers/refresher courses in first aid, especially CPR

The State Coroner found that one officer involved in this matter was not trained and at the time of inquest was still not trained in first aid. He listened

to the Acting Governor of the Institution and noted that a program is in place to have all officers trained in First Aid as a priority. He also noted ACO (Assistant Commissioner's Order) 2000/058 of 27 June 2000. Whilst recruitees to the Service are required to have a First Aid Certificate by the time of graduation, many officers are still not trained in First Aid. He considered it incumbent on the Department to ensure that this situation is rectified as a matter of urgency so that all officers are certificated and then annually refreshed. He appreciated the logistical problems for the Department but observed that the task had to be attended to with urgency.

4. Adequacy of personal OH & S kits, especially face masks

The Coroner found these to be barely adequate. They are flimsy and one officer's ripped on this occasion rendering it useless. He recommended that the Department investigate the feasibility of obtaining more efficient, portable masks to go into Officers' AIDS kits.

5. Alteration of the Control Room Log

The State Coroner was satisfied that the log was altered, replacing either 11.03 or 11.05 with 11.08. He was unable to say who altered it. He noted that a Departmental Investigation could not ascertain who altered the log. He commented:-

"Deliberate alteration of important documentation in order to mislead is a most serious matter and may warrant dismissal from the Service or worse. Regulation 33, Crimes (Administration of Sentences) Regulation provides that "a correctional officer must not destroy or mutilate, or alter or erase any entry in, an official document." A penalty is provided.. The Department, if it has not already done so, must give a directive to all officers in this regard. ....."

Finding

That [the deceased] died on 1 December, 1998, at Goulburn Base Hospital, Goulburn, of hypoxic brain damage after he hanged himself in his Cell, Number 10, of 2 Unit, Goulburn Correctional Centre, Goulburn on 29 November, 1998, with the intention of taking his own life.

Recommendations

1. a). That the Department of Corrective Services reviews its present procedures for obtaining statements from Correctional Officers closely involved in deaths and incidents in custody to ensure that those procedures are adequate, in that such officers are promptly separated and that a senior officer of the Institution takes responsibility for the proper taking of such statements.

   b) That Present ACO 98/091 be strictly adhered to in the interim.

2. That the Department of Corrective Services reviews the present issue of face masks in AIDS Kits and investigates the feasibility of obtaining a more effective, portable device.

3. That the Department of Corrective Services reminds all officers of the provisions of Regulation 33, Crimes (Administration of Sentences) Regulation, and instructs such officers as to the circumstances in which and the method by which documentation can be altered.

108 of 1999 **Male of 20 years died on 7 January 1999 at Cessnock Correctional Centre. Finding handed down on 2 March 2000 at Raymond Terrace by Dr Elwyn Elms, Acting Deputy State Coroner**

The deceased had been in the prison system for about three months at the time of his death, spending most of his time at Cessnock. He was perceived to be a disruptive influence and, along with other inmates, was placed on the Cessnock Management Programme, which was designed to cause him to address the reasons for his behaviour. The Governor gave a direction, the effect of which was that M was to be placed '2-out' in a cell. This direction was not followed, and M was placed '1-out'. Three days after being placed on the Programme, M hanged himself in his cell, utilising an obvious hanging point formed by the junction between a vertical and horizontal bar in the ventilation aperture above the cell door.

Circumstances of death

On 30 September 1998 M was arrested in a stolen motor vehicle in company with his girlfriend B and a female juvenile in the Nabiac area. He was then on parole for a previous offence. His parole was revoked in view of his failure to keep in touch with his parole officer and his failure to notify his change of address, and he was sentenced to serve the balance of his term expiring on 26 June 1999.

On 14 October 1998, M was transferred to the Metropolitan Remand Centre at Long Bay. He appeared at the Penrith Local Court on 15 October and was sentenced to twelve months imprisonment, his release day being 14 October 1999. On 9 December 1998, M was transferred back to the Cessnock Corrective Centre. On the following day, he met with Nurse A, a registered nurse. Her notes record:

Came in on escort yesterday. Says has lots of relationship problems. Not coping very well. Came to Clinic today requesting 2 out. Same attended. Please review. Still has 12 months to serve.

Nurse A did not specifically remember her interview with M. However, from her notes, it appears he was seen at the Clinic and that she attended to his request to be placed two out, requesting a review since M still had a significant portion of his sentence to serve.

He was referred to, and was seen by K, then an intern psychologist, on 22 December. K recorded that his relationship problems seemed to have resolved themselves at the time of interview. Her notes record:

Requested 2-out as wanted to be in with his mate ® mate now 1-out. (S) was able to engage, he presented reasonably well & thoughts were coherent. Denies any history or current self harm (suicide) ideation and remained future oriented.

K explained this by saying that *at the time of referral* M had requested 2-out, but that the friend whom he had wished to be with was now 'contentedly in a one-out cell'. M informed her that he 'was no longer requesting this particular arrangement and wanted to be transferred to a one-out cell'. Nevertheless, she did not change his status, because he had been placed two out by Correctional Health Service staff.

In fact, throughout this period, M remained 2-out until he was placed on the Cessnock Management Programme on 4 January 1999 because of his unacceptable behaviour: firstly, using abusive and insulting language to a Corrections Officer - this occurred on 8 December at the Metropolitan Remand Centre just before M proceeded under escort to Cessnock. He continued to abuse staff while waiting in the holding yard. He was sentenced to 14 days off canteen buy ups when he reached Cessnock, and refused to sign the charge sheet when informed of the decision. Once he reached Cessnock, he committed further breaches of discipline and routine such as refusing to go to his cell at lock in (resulted in 24 hours in cells) and failing to line up correctly in the muster.

On 3 January 1999, Assistant Superintendent C, the Area Manager, recommended that M and seven other inmates be considered for participation in the Programme. On 4 January, C's recommendation was by the Governor, the Deputy Governor, and the Programme Manager. The fact that these inmates were to be placed on the Programme required them to be moved from 1 Wing to 2 Wing.

After M was selected for inclusion on the Programme, his obligations were explained to him and he entered into a contract with the gaol authorities containing the following conditions:

No more misconducts
No negative comments on running sheets
Participate - D & A (Drug and Alcohol counselling)
Anger Management

The night before he died, M played cards with the occupant of the adjoining cell P by means of a hole in the wall between the two cells. About 10 pm, M said that he wished to write some letters. He was found the next morning hanging in his cell. A sheet had been placed around his neck to fashion a noose and the other end was secured around the junction between a horizontal and a vertical bar in the ventilation aperture above the door. P detected nothing which would in any way suggest that M was contemplating taking his own life.

The Acting Deputy State Coroner was satisfied that M took his own life. He was locked in his own cell, and left a number of letters to his girlfriend and other friends indicative of his intention to take his own life. Other comments on the notice board and the cell wall were to similar effect.

M's body exhibited a number of bruises about the face. The inquest heard evidence that as M's body was being moved from one trolley to another within the morgue, regrettably the second trolley moved and M's body fell to

the ground heavily on his head. Members of the family were not satisfied that this was an adequate explanation for the bruising because 'dead bodies don't bruise'. From this it may have been thought that M was in some way the victim of foul play.

However, the inquest heard evidence that the bruising on M's face was not evident when he was found in his cell, whereas it is clearly evident on the photos taken at the post mortem. Dr F said that dead bodies can bruise for up to a day after death and probably longer if there is still blood in the vessels. The evidence was to the effect that M's body was placed in a body bag at the cell, that it was sealed, and that the seal was not broken until after it arrived at the morgue. The Coroner was satisfied that the bruising to M's face after it arrived there was consistent with and the result of the fall when it was being moved from trolley to trolley. He was not satisfied that M's death was the result of foul play, and found that he died as the result of a decision to take his own life.

He was also satisfied that Correctional Services staff could not reasonably have done anything to anticipate M's decision to take his own life. He gave no indication to those about him, whether inmates or Correctional Services staff, in the weeks, days and even hours before his death that anything was untoward. The Correctional Services staff could not be criticised for not anticipating something concerning which there were no exterior indicators. They were trained to look for such signs, but none were evident.

There was some tension in the relationship between M and his girlfriend B who was an inmate at Emu Plains. Nevertheless, whatever M may have been feeling inside about his relationship problems with B, the evidence is that, so far as the other inmates at Cessnock were concerned, these problems seemed to have resolved themselves. And so it appeared also to the psychologist when she saw him on 22 December when M himself requested to go one out.

Issues:

1. Why was the Governor's direction not implemented? What can be done to ensure that such directions are implemented in the future?

M's placement on the Programme and the direction for "2-out"

One of the significant problems the inquest had to deal with is how M came to be placed one out when he was placed on the Programme. Assistant Superintendent C said that at the meeting on the morning of 4 January, she was told by the Governor that M only of the 7 inmates she had recommended for the Programme should be placed 2-out. The Governor gave a diametrically opposite version. He said that he directed that all seven inmates recommended for the Programme should be placed 2-out after it was pointed out to him that all were young offenders, and was supported in this account by three others who were present at the time. The direction for 2-out was given, he said, because all were young offenders, and so that each could gain some support from a colleague and compare experiences while on the Programme.

The Coroner accepted the evidence of the Governor where it conflicted with the evidence of Ms C. However, both parties were in agreement that M was to placed 2-out and this did not occur. C said that she passed on the direction to N who, when asked, said that he had no recollection of the event, which, in the Acting deputy State Coroner's view, was not surprising, since he was not asked to recall the events of that day until some four months afterwards. She also says that she informed Prison Officer S who was on duty in 1 Wing that the seven inmates were to be moved onto the Programme in 2 Wing and to pass on all relevant information including the 2-out status. Mr. S is since deceased.

Nothing was recorded in writing, not the Governor's direction, nor C's instructions to N, even accepting for the moment that they were given in the form in which she asserted. The Governor said that the instruction he gave should have appeared on the Case Running Sheet in the case Management File and that the running sheet detailing the daily conduct of inmates should have been placed in the Wing Office. It didn't. He also says that the direction C passed on to N should have been entered in the Wing Log. It wasn't. Instead these important directions were endorsed on scraps of paper or pages in a notebook which were subsequently discarded. As the Governor said, this was a lazy way of doing things.

C said that she did not have the time to record every direction she received and every instruction she gave. However, the Acting Deputy State Coroner said that important instructions such as a Governor's direction that a prisoner placed on the Programme for reasons of youth or aboriginality was to be placed 2-out should obviously be recorded in a formal way so that anyone who needed to know, on a changing of shift or otherwise, was able to see what the situation was from the gaol's formal records. They were in exactly the same situation as a prisoner who presents from the Clinic or Psychologist with an endorsement of their 2-out status. They are accompanied by a written record of their 2-out status, and a similar endorsement or notification should also have been made in some formal way in the circumstances under consideration. The written instruction should also be followed up to see that it has been complied with.

The aim of the exercise, said the Coroner, was not to apportion blame to one party or the other, but simply to note that on this occasion, the system broke down. The Governor said that henceforth all prisoners on the Programme would be placed 2-out, and the Coroner agreed that that was desirable. It would obviously not remove completely the risk of hanging - cases have occurred when prisoners have hanged themselves whilst 2-out - but it would minimise it.

Another factor worthy of mention is that M was allocated a Case Officer with whom he had no contact because the latter was in a different area. How this occurred was a mystery. A Case Officer may have assisted M in unburdening himself if he had any problems. He would generally see the inmate at intervals of 28 or more days. In the Inquest of B (16 October 1998), reference was made to the lack of a Case Officer for that inmate under somewhat different circumstances (Mr.B was a remand prisoner). The then Senior Deputy State Coroner, commented upon the importance of a Case

Officer to the case management system. What occurred in this case may have been an aberration, and the Governor inferred that things had now improved. However, the fact that did occur, together with what was said in Mr.B's case was reason enough for the Coroner to make a recommendation that steps are taken to ensure that all prisoners are allocated a case officer and that they meet with that case officer as soon as practicable after they enter the Cessnock complex.

The Coroner said that he did not intend to make a recommendation about all prisoners on the programme being placed 2-out because the Governor said that that is now gaol policy. However, he did intend to recommend that henceforth steps were taken to ensure that all significant factors affecting a prisoner's status, and particularly his 2-out status whilst on the Programme, be endorsed on the Case Running Sheet and the Wing Log. This was apart from any health Notification Form that may be relevant. It may be, said the Coroner, that that now also represented prison policy. However, during the inquest comments were still being made concerning the lack of time to do such things, and the impression the Coroner gained was that important directions may still be being recorded in a notebook then discarded or on scraps of paper. The witnesses who gave this evidence portrayed it as what they normally do, not what they did.

2. The hanging point

Another area of significance for the inquest was the hanging point in M's cell. This was in the ventilation area above the door. The photographs showed that there is mesh installed there, forward of which within the cell there are two steel bars, a thinner horizontal bar and a flatter vertical bar. The junction of these two bars was utilised for the purpose of tying the bed sheet that M used to hang himself with. The Coroner was informed that one of these bars was the remnant of the support for louvres previously used in the cell until the prisoners destroyed them. The horizontal bar is to stop the prisoners kicking out the mesh behind it. The Governor said that it is impossible to close off all hanging points in a cell, and that other points within the cell can be utilised for this purpose.

However, the Coroner said that *obvious* hanging points such as the one utilised on this occasion should be removed or closed off in some way. It would be a tragedy if a death were to occur in precisely the same fashion in the future. Mr. B had managed to hang himself from precisely the same hanging point when there were louvres there. Recommendation 165 from the Royal Commission into Aboriginal Deaths in Custody recommended that 'steps should be taken to screen hanging points in police and prison cells'. Expense and competing resources are naturally important, said the Coroner, but if expense stood in the way, it was difficult to see hanging points ever being modified..

The Coroner said that it was his intention to recommend that the hanging point above the cell doors in the complex should be either removed or screened with mesh in such a fashion that still preserves security. If possible, consistent with ventilation, the holes in the mesh should be small enough to ensure that prisoners are unable to force substances which may potentially

used for self harm through the holes and back again. He reiterated that the existing hanging point in the form of a junction between two bars, and easily accessible to any one standing on a chair, is an obvious one and must be removed.

Other subsidiary issues raised by the family are referred to in the judgment

The Programme

The Cessnock Management Programme is an initiative of the Cessnock Corrective Centre. Its aim is to effectively manage identified inmates who have demonstrated unacceptable behaviour and an inability to comply with the normal routine of the prison. Inmates placed on the programme are offered the opportunity to modify their behaviour in identified deficient areas. This is achieved in a structured, interactive environment where inmates are closely monitored by staff who are dedicated to the principles of the programme. Inmates participate in a structured programme developed in accordance with an individual management/ behavioural contract that they sign. The prisoners on the Programme lose privileges in the sense of being able to mix with other inmates until their behaviour improves. There was evidence to the effect that the programme has been effective in modifying inmates' behaviour and that the number of assaults on Corrections Service staff and other inmates and other incidents declined as a result.

In the Coroner's view, the Cessnock Management Programme is a most worthwhile initiative. Whilst it may be said that an inmate's past behaviour is the reason for being placed on the Programme, the Programme is not designed as a punishment for past misdemeanours, but rather as a vehicle for the inmate to address the causes of his behaviour. Thus M agreed to do courses in Anger Management and Alcohol and Other Drug Counselling.

It was submitted on behalf of the family that M should have been monitored or supervised more. The Coroner said that the Programme, with its highly structured and interactive environment, contained its own in-built mechanism for supervision, and that the prison authorities would have been subject to criticism had M not been placed on the Programme and left to his own devices to vent his anger and cause disruption elsewhere within the complex. Ms R, a family member, highlighted a recommendation from the Royal Commission's Report into Aboriginal Deaths in Custody (par 24.3.99) to the effect that "In practical terms what is required is that, where persons exhibit signs of anger and aggression, they should be kept under reasonably close supervision". The Coroner said that this was precisely what the Programme was designed to achieve or at least that was its effect. Where the system broke down on this occasion was in the failure to implement the Governor's direction about having him placed 2-out. Again, this would not have eliminated the risk entirely, but it would have modified it. But the Programme itself was in no way the proximate cause of M's death, said the Coroner.

Other matters

The Coroner was also satisfied that there was no undue delay in nursing staff attending to M after he was found, nor did the evidence satisfy him that resuscitation equipment should necessarily be placed in the wings.

The Coroner concluded by complimenting Officers B and D and Officer Deal on their outstanding efforts in administering CPR for the period they did in an effort to save M's life. He said that they reflected great credit on themselves, their office and their Department. He conveyed his personal condolences to members of the family.

Finding

That [the deceased] died on 7 January 1999 in Cell 2209 of Wing 2, Cessnock Correctional Centre by hanging, self inflicted with the intention of taking his own life.

Recommendations

1. That the hanging point in the ventilation aperture above the cell door in Cell 2209 and others like it be removed or alternatively that it be covered with some form of secure mesh.

2. That steps be taken to ensure that departmental policy regarding the allocation of case officers to inmates are adhered to at the Cessnock Correctional Centre, that inmates meet with their case officer as soon as practicable after they enter the complex, and that thereafter they meet with him regularly at least every 28 days

3. That steps be taken within the Cessnock Correctional Centre to ensure that henceforth all significant factors affecting a prisoner's status, and particularly his 2-out status whilst on the Programme, are endorsed as soon as practicable after they occur on the prisoner's Case Running Sheet on the Case Management File and the Wing Log. Follow up to see whether any particular direction in this regard has been complied with should occur as soon as practicable and in any event within 24 hours.

73 of 1999 **Aboriginal male 26 years died on 11 January 1999 at Silverwater. Finding handed down on 31 August 2000 at Glebe by the Jacqueline Milledge, Deputy State Coroner**

Mr. H was an inmate of the Metropolitan Remand and Reception Centre. He was received into that facility on 7 January 1999. He was found dead in cell 470, Hamden 15 on 11 January 1999.

Mr H, a 26-year-old aboriginal male, was an unsentenced prisoner, having been remanded in custody after his arrest on 11 September 1998 at Wagga Wagga for Armed Robbery. Mr H was due to attend the Sydney District Court, Downing Centre on 12 January.

Mr H had previously been received into Junee Correctional Centre immediately after his arrest. He stated later that should he be returned to Junee he would 'self harm'. Mr H was kept at the MRRC as he was an escapee and no other holding facility was considered an option for that reason.

He has a long and extensive criminal history, involving matters of violence and drug use. His history as an inmate is commensurate with his criminal antecedents. He was known for acts of violence against other prisoners and correctional officers, illicit drug use and self harm issues.

Events prior to his death

During a muster of inmates at noon on 10 January, a Correctional Officer noticed both deceased and his cell mate affected by some substance.

H shared a four out cell with two other inmates, and later that afternoon that cell, Cell 470, was targeted for a search by the Drug Dog Detector Unit. During the search H was strip-searched and a white rock substance was seen to fall from Mr H's underwear. The search of the cell revealed some green vegetable matter, a matchbox with foil containing more white rock substance, and drug implements.

The deceased's cell mate, describing himself as a 'brother' to Mr H, gave evidence that he had been with H in another facility and saw ' him shoot up heroin in the cell a couple of times'. They were both transferred to Silverwater and he gives evidence of H's continued drug use despite being incarcerated.

On the Friday before his death W witnessed H inject himself about lunchtime, "he was pretty stoned for the rest of the day". W continues " he told me he was buying some on Saturday off one of the other inmates". W saw the 'gear' that was purchased on that day.

He states, "He showed me a rock of heroin that was wrapped up in plastic. I reckon it would have weighed about half a gram. He told me he was going to cut it up and make money with it". The heroin was eventually concealed in the lid of a shampoo bottle.

Later that day both H and W injected themselves with heroin. W was also with H the next day when H used a disposable razor to prepare ten 'deals'. They were put in coffee satchels, placed in a matchbox and concealed in H's trousers.

The following day H again used heroin in the morning prior to 'let go'. W states he walked around the pod and intended to get rid of his deals. This indicates that H was not only using heroin but was dealing in the pod.

W confirms that the cell was searched in the afternoon and H's syringe, pot and heroin were found. He said that they failed to locate the other heroin contained in the shampoo bottle.

After the search, H told W he would get the 'sweeper' to secure another 'fit' for him. When that arrived H walked into the bathroom and sometime later staggered out. H collapsed and was placed on the bed.

It was the next morning that W tried to arouse him and, realising he may be dead, summoned help.

From the accounts of Mr W, he and H engaged in constant drug use whilst inmates in Hamden 15. He gave evidence that he was able to swap drugs with other inmates, consuming some thirty pills on the day leading up to H's

death. He also said he 'had five shots that day' and believed H was trying to keep up with him "I had a $2000 day habit and he came from the country on a $50 habit."

The family raised a number of issues during the inquest

1. That H was not a drug user

There is no doubt that H was indeed a drug user. His friends gave evidence that they knew H to use drugs in the past.

Dr Cala, pathologist, also found physical indicia supporting prior drug use, numerous puncture marks to the elbow consistent with intravenous drug use. The level of morphine detected in the bile indicates heroin use over several days prior to death.

2. Why was H not examined by medical staff

Whilst it is accepted that both W and H were seen to be drug affected during the course of the day, correctional officers believed they were not adversely affected by drugs and there was nothing that warranted calling the clinic.

The Assistant Operations Manager believed nursing staff had seen the deceased and his cellmate.

Officer M remembers the Assistant Operations Manager asking the nurse to describe the contraband and whether she required the inmates to be taken to the clinic. M remembers the nurse stating 'no they're alright'. The nurses denied being asked to comment on W and H.

This contradiction in accounts does not allow me to say if the nurses were asked specifically about W and H. I am satisfied that as far as the correctional staff were concerned they raised the issue with nursing staff. It may be that as the nursing staff were alerted to the other prisoner and were called to his cell with the appropriate file, that there was a real misunderstanding of what was being asked. This is only speculation on the evidence before me.

It was only after the search that H's condition deteriorated quickly when he retreated into the bathroom emerged half hour later and collapsed on the floor.

3. Was H considered 'at risk'

Doctor M, Director Clinical Services, Corrections Health Services, explained that H was first received into the Junee private facility under the care of Australian Correctional Management, not the Department of Correctional Services. He states that whilst H was classified 'at risk' because of a previous history of suicide and attempted self-harm, he wasn't assessed as a 'current risk'.

His file shows that on admission to Junee in September he was referred for detoxification assessment, to the psychologist, medical staff, risk intervention team and drug and alcohol counselling as a result of his intake assessment. Over the next several days his file indicates a number of follow up visits. At the time he completed his intake assessment he admitted to 'using' for the six months prior.

Dr M explained the difficulties in having inmates participate in drug and alcohol counselling, stating that it is up to the prisoner to keep appointments after the first approach is made. He describes the remand period as one of great uncertainty when trying to involve inmates in worthwhile programs.

Dr M states there are 16,000 receptions a year, 70% of whom are on remand. 9000 have a history of drug use and 3000 are still injecting in the prison system. There are 7,500 escorts per month.

On 19 October 1998, H returned from a court visit and had his warrant endorsed requesting "medical and psychiatric reports". Dr M states that while H received a medical assessment, however there was no evidence that Mr H was mentally ill. He stated that courts often request psychiatric assessments, and as a result the demand is great. For this reason it is up to his staff to determine if one is necessary.

4. How is it possible that drugs can be found in goal?

The cellmate stated in his evidence that the officers cannot look everywhere for drugs as the amounts are small and prisoners know how to conceal them from detection. He provides a stunning insight into the availability of drugs but states that they are harder to come by these days than before.

There is evidence that visitors will carry drugs into prisons, projectiles over walls will contain contraband, and disreputable staff can be responsible for the introduction of substances. Drugs are purchased by other prisoners by arranging payment outside the institution.

There is evidence that H himself was dealing in heroin.

The Coroner is satisfied that considerable effort is being made by prison authorities to reduce drugs in prison. The drug reduction policy has been implemented, search procedures have been strengthened and, as W said, there are not the levels of drugs in prison as there were before. His opinion as an experienced inmate is that it will never be completely stopped.

The Coroner is satisfied that on this day 10 January, correctional officers did what they could to deprive H of his store of drugs.

When W and H were noticed to be drug affected, a target search was conducted on their cell. All occupants were stripped search and drugs were found and confiscated.

The Coroner is satisfied that Mr H did not intentionally take his life. Whilst he was facing a long period of incarceration if found guilty, his co-accused said they were both optimistic as they had worked out a plan of defence.

Finding

That [the deceased] died between the hours of 4.05pm on 10 January and 5.55am on 11 January 1999 in cell 470 Hamden 15 Metropolitan Remand and Reception Centre Silverwater as a result of opiate intoxication, self-administered.

I am satisfied that his death was accidental.

Recommendations

1. That all identified illicit drug affected prisoners be assessed by Nursing and or medical staff.
2. That each referral and assessment be documented on prisoner files with the time and date referred, time, date and person conducting the assessment and the action taken.
3. That prisoner files be endorsed to show all referral, whether appointments or follow visits undertaken and if not, the reasons why.

239 of 1999

Male aged 35 years died on or about 23 January 1999 at Cessnock Correctional Centre, Cessnock. Finding handed down on 3 March, 2000 at Cessnock by Dr Elwyn Elms, Acting Deputy State Coroner

At the time of his death, the deceased was on remand awaiting sentence in the Newcastle District Court on charges of attempted robbery whilst being armed and in company, break, enter and steal, breach of recognizance and escape from lawful custody. Following his apprehension, it was discovered that the deceased had been an escapee from the Emu Plains Correctional Centre since 1983. He was received into the Cessnock Correctional Centre on 14 November 1998.

He was seen by Nurse M on the same day. She noted a history of self-harm, an attempt at gassing himself in the oven 5 months previously and a slashing of the cubital fossa 2 years before. He also stated that he had had thoughts of self-harm and suicide the day before - 'thoughts of hanging himself due to gambling debts'. The deceased was placed 2-out in a cell until seen by the psychologist, Ms P, on 17 November. She also recorded a history of self-harm, and also noted that he suffered from depression. He 'denied any current suicidal or self harm ideation and expressed future orientation'.

On the 19th, he was seen by a Ms V, the welfare officer and was referred to the psychologist for assessment for transfer to a 1-out cell. As a result, on 14 December, he was seen by Ms K, the intern psychologist. He presented well and was due to go to court the following day. She noted that he had been 1-out on a number of occasions. 'There is no current self harm suicidal ideation'. He would self refer for future contact. From that time onwards, until his death on or about 23 January 1999, over a month later, he was 1-out.

On that day, the deceased was found dead in his cell. There was no suicide note. However, the Acting Deputy State Coroner (hereinafter referred to simply as the Coroner) said that there was no doubt that the deceased had committed suicide and that he did so in a most inventive and unusual manner. He had tied the cord from the television set around his neck after having placed his head in a plastic bag. He was lying on a metal shelf consisting of a mesh base. The flex from the cord passed through the mesh that was tied to the top of the bed. The bed was partially suspended, and the deceased had used the weight of the bed to tighten the flex as it moved. The weight of the bed was some 25 kilos. A handkerchief had been knotted through his shorts and tied to the mesh on the shelf apparently to prevent the bottom half of the body falling off when the deceased was no longer able to control it. The deceased's head was also encased in a pillowslip. The cause of death was suffocation, due no doubt to the head being encased in the plastic bag.

There were no signs of a struggle, apart from some paint flakes on the deceased's toe, apparently caused by the deceased's final death throes. There was no one else in the deceased's cell that was in the maximum-security section of the gaol.

No one from the gaol noticed anything untoward about the deceased behaviour. In fact, he was a bit of a loner, apparently a widower, and had no next of kin, or at least none that could be located. He had no visitors whilst in gaol.

Although he reported a history of self-harm when interviewed at the Clinic and to the Psychologist, he exhibited no external signs that he was in any form of emotional distress, denied any suicidal ideation and appeared and said that he was future oriented. He requested a referral for 1-out on 19 November, that was approved on 14 December and he died over a month later. In my view, it would not have been reasonable to have kept him 2-out indefinitely when he appeared to be showing no signs of outward disturbance, and indeed that might also have been counterproductive.

The Coroner said that the mode of death required considerable planning and forethought. It was unique and bizarre. No obvious hanging point was utilised. The Correctional Centre could not reasonably be expected to anticipate it. Nor could anyone within the prison be expected to have anticipated his decision based on the manner in which he presented to the clinic and to the psychologist and the fact that there were no exterior indicators. This was so notwithstanding the previous history of self-harm. Under the circumstances, the Coroner felt that there was no reason the make any recommendations.

Findings

On or about 23 January 1999 [the deceased] died in Cell 4231 of the 11 Wing complex of the maximum security section of the Cessnock Correctional Centre, of suffocation in conjunction with strangulation self inflicted with the intention of taking his own life.

261 of 1999

Male 49 years died on 7 February 1999 at Silverwater. Finding handed down on 31 August 2000 at Glebe by Jacqueline Milledge, Deputy State Coroner

This is an inquest into the death of Mr. B, an inmate of the Metropolitan Remand and Reception Centre. Mr B was found hanged in his cell on 7 February 1999.

Mr B's children did not want any inquest into their father's death and that they did not express any concerns regarding duty of care or issues relating to the treatment of their father in prison.

Background

Mr B was 49 years of age at the time of his death. He was on remand for numerous sexual offences on males. Mr B came into police custody at Katoomba on 18 November 1998 and at that time he requested protection as he was concerned for his welfare whilst incarcerated.

He was moved to the Metropolitan Remand and Reception Centre on 19 November. On intake he was assessed where he participated in a comprehensive mental and physical assessment. He told the nurse that he had tried to suicide by overdosing on anti-depressant medication some months earlier (this was also mentioned to police by his daughter). He expressed feelings of depression and abandonment and was also concerned about the extensive publicity surrounding his arrest.

He denied any suicidal thoughts and the nurse formed the opinion he was not overly depressed. She recommended a 'two out' cell and noted the file that he may have trouble coping in prison.

As a result of this assessment, Mr B was seen by the Crisis Intervention Team the following day. Mr B's medical notes indicate he was seen regularly by psychiatric and nursing staff.

The Psychiatrist Dr P consulted with Mr B on 30 January 1999. He was treated for major depression. Anti-depressants were prescribed and his condition was to be reviewed within 14 days. Sadly Mr B died within that period.

From the very first day of admission to the MRRC, Mr B had requested to be classified 'Strict protection - non association'. This saw him placed 'one out' in Darcy Wing Pod 13. The Crisis Intervention Team, medical staff or indeed Dr P did not at any time feel the need to alter his status.

The incident

On the day of his death, Mr B showed no outward signs that anything was untoward or that he was depressed. Correctional Officers saw Mr B several times during the course of the day. The last time was at lunchtime approximately 12 noon.

At 3.25pm when both men were attending to the exercise areas of the cells they noticed Mr B suspended by a piece of white cloth attached to the overhead bars of the exercise yard at the rear of his cell. Officer McL held the deceased as Officer B used his 911 tool to cut Mr B free. Mr B was immediately placed in the recovery position and clinical staff were summoned immediately.

It was the opinion of the medical team that CPR would not be appropriate given his condition as "he was too far gone".

Issues

1. The ligature

It was suggested during the course of the inquest that the blankets used by inmates were of poor quality and were 'second hand', therefore easy to tear. This was not the case. Evidence of Officer Bridge puts to rest that proposition stating blankets are received 'new' and indeed are still in their packaging.

2. The plastic chair

In this instance Mr B's cell was equipped with the chair to allow him to sit in the sun in his exercise yard. In deciding to remove this type of furniture, it

must be carefully considered that when used as intended it is an extremely serviceable piece of equipment for inmates. There must be a balance between issues of safety and allowing the majority of inmates comfort, dignity and humane treatment.

3. The cell bars

Evidence was given that even without the chair, a fit inmate could easily jump up to reach the bars and gain leverage. There would be no impediment to have the bars raised 'out of reach'.

The issue of 'hanging points' has been addressed in many other inquests.

4. CPR

The Coroner accepts the reason as to why CPR was not undertaken. I am however concerned that CPR equipment ie gloves and mask etc may be located in offices that are some distance from some cells. This was not the case here as Mr B's cell was close to the office area, others are not. CPR equipment should be readily accessible to all cells. Officers should not have to return to the office to secure the kit.

5. Should Mr B's suicidal inclination been detected - Mr B's daughter R

Mr B, on assessment had alerted prison authorities to an earlier incident of self harm by overdose and this was properly noted on his medical records. He had at all times in the prison system received timely and appropriate treatment.

He was seen by the Crisis Intervention Team, medical personnel and psychiatrist. The prison officers were alert to his condition. There were no recent indications that he would self harm. Indeed Mr. P, his friend in the next cell, had no indication that he was depressed.

The Coroner is satisfied that the response to Mr B was appropriate in the circumstances and that Mr B's death by hanging was impulsive.

Finding

That [the deceased] died between 1.50pm and 3.25pm on 7 February 1999 at the Metropolitan Remand and Reception Centre Silverwater, Darcy Wing Pod 13 as a result of hanging

Recommendations

1. That resuscitation equipment ie gloves and oxy facial masks be contained in kit form and placed within easy reach of each and every cell.

2. That the design of future correctional facilities embrace the need to segregate sex offenders on protection from other violent and segregated prisoners to ensure verbal and physical contact is minimised.

505 of 1999 **Aboriginal male aged 49 years died on 13 March 1999 in the Intensive Care Unit, St. George Hospital Kogarah. Finding handed down on 15 November 2000 at Glebe by John Abernethy, State Coroner**

This 49-year-old male aboriginal prisoner died on 13 March 1999 in the Intensive Care Unit, St. George Hospital Kogarah. He died of complications of biliary surgery.

The family of the deceased was competently represented at inquest.

All interested parties agreed that there was no issue involving the custody of the deceased and that it was appropriate for the inquest to focus on the care he received in the New South Wales hospital system.

The deceased was a sentenced prisoner. Prior to his transfer to the Prince of Wales Hospital, Randwick, on 26 February 1999, he had, from 14 February been a patient at the Long Bay (Prison) Hospital. He was competently cared for there. He was a schizophrenic, compliant to medication but was suffering various physical symptoms. He was found to have gallstones and so was transferred for surgery to the Prince of Wales Hospital. His transfer was both timely and appropriate.

Though the deceased, in effect, died of a natural cause, or medical misadventure, his death comes within *Section 13A, Coroners Act 1980.* For statistical purposes, therefore, it will be a "death in custody", though the same issues would have arisen had the prisoner not been in custody. To that extent, perhaps, death in custody statistics can be a little misleading and must be treated with caution - for statistical purposes this is yet another aboriginal death in custody.

The medical issues were carefully canvassed at inquest.

Finding

That [the deceased] died on 13 March 1999 whilst in custody, in the Intensive Care Unit, St George Hospital, Kogarah, of complications of biliary surgery undertaken on 26 February 1999 by Dr. S, at the Prince of Wales Hospital, Randwick.

558 of 1999 **Male aged 23 years died on 19 March 1999 at Silverwater Goal. Finding handed down on 11 January 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner**

Circumstances of death

The deceased was a 23 year old man who was remanded in the MRRC at Silverwater Gaol being bail refused at Penrith Local Court on 17 March 1999 for the offence of break enter and steal. He was at the time of arrest serving a term of periodic detention.

Mr. L had no antecedents relating to drug offences and was not believed by his family to be either drug dependent or a user of 'hard' drugs. He was placed into Darcy Pod 1 and was assessed as per normal protocol on the 18 March and transferred to Goldsmith Pod 11.

He was placed into a prison cell to be shared with another prisoner who was absent from the cell area at the time. When the prisoner F, with whom Mr. L was to share the cell, returned later that afternoon he found Mr. L asleep on his bed.

He left him to sleep and when 'muster' was called at 3pm left him to sleep but informed prison officers. Two prison officers entered the cell, spoke to L who muttered to them and continued to sleep. Prison Officers left him in the cell and organised for another prisoner to bring him his evening meal and leave it in the cell.

Upon F returning from 'muster' he still found L asleep and snoring and did not attempt to wake him. F watched television until he fell asleep about 7pm after trying to wake L. F awoke at about 10pm and found L in the same position still snoring. He left him on the bed and awoke again about 1am to use the toilet.

F returned to his bed, tried to sleep and then at some time later realised his cell mate had stopped snoring and he could not see his chest rising and falling. He went to L but could not find a pulse and alerted prison officers by means of the 'knock-up button'.

No drugs were located in the cell or upon the person of F and no visible injuries were located upon the deceased.

Evidence was received from prisoners that the deceased had been seen prior to his being placed in a cell in Goldsmith Pod in a drug-affected state. Prison officers denied this.

At post-mortem no physiological cause of death was found however toxicological results showed morphine in blood and bile. Cause of death was opiate intoxication.

Issues

Family members were concerned as the deceased had always stressed he was anti-drugs. Where had the morphine been obtained? Was the drug self ingested?

Concerns as to why prison officers did not note deceased was drug affected and also why he was left in the cell during muster.

Inquest

No issue that the deceased self ingested the morphine or that he had used the drug prior to his death. Evidence provided by some prisoners that the deceased was showing signs of obvious drug ingestion was equivocal. The two prison officers were dealing at the time with a large number of prisoners and were supported in particular by the prisoner who supplied linen to Mr. L shortly before he entered his cell.

Evidence by the prison officers that upon receipt of new inmates to the pod they were given some 'lee way' as to the second muster as they are often overwhelmed by the environment and many of them coped by sleeping.

The prison officers presented as honest forthright witnesses acting in a compassionate and reasonable manner. Their actions were not the subject of any criticism.

Findings

That [the deceased] died on the 19 March 1999 at Silverwater Correctional Centre in the State of New South Wales of morphine intoxication administered by his own hand.

559 of 1999

Male aged 28 years died on 15 April 2000 at Silverwater Goal. Finding handed down on 14 June 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner

Circumstances of death

The deceased was serving a sentence of 2 years and 6 months with an additional term of 2 years and 6 months for property offences. The release date was the 26 October 2003.

On the 17 December 1998 the deceased spoke of feeling suicidal as he was preparing for a further lengthy term of incarceration. Prior to his last period out of custody the deceased had been on the methadone program. He was placed back on this program upon his return to gaol.

Whilst on a low security rating Mr. D absconded from the Norma Parker Centre on the 21 March 1999. He left to spend time with his fiancée who he believed 'needed' him. Upon his recapture he again made an unsuccessful escape from custody whilst at Central Local Court. He was returned to custody on the 13 April where he was assessed by staff as being drug affected and suffering from drug withdrawal. He was not considered at risk from self-harm. The assessment of the deceased was mainly based upon self-assessment. Mr. D's brother was in custody at the same time as himself and he asked to be placed with him. This couldn't be considered at this time due to Mr. D being placed in the detoxification unit.

When seen the next day (14 April) by a more experienced nursing staff, Mr. D was noted not to be withdrawing from drugs and was placed into the general prison population. (The application for placement with his brother was being considered at the time of Mr. D's death).

At about 8.55am on the 15 April 1999 two prisoners in a cell opposite Mr. D's saw a piece of white material looped through the grill over Mr. D's door. They activated the 'knock-up' button and prison officers attended to investigate. Mr. D was located deceased with sheeting around his neck. He had hung himself.

Issues

Should the deceased have been given more than Valium (Diazepam) to assist his 'withdrawal'. Should he have been on the methadone program. Should the deceased have been placed into a cell with his brother.

Inquest

At Inquest it was ascertained the deceased did not present as a risk of self-harm. The nurse who examined the deceased on the second occasion is more experienced and his opinion was not in dispute. Correctional Health staff

were not able to have the deceased placed on the methadone program as he had to be re-assessed by the Health Department for re-entry to his program. Valium is an accepted medication for persons in the position of Mr. D who are not on the Methadone Program.

At the time Mr. D took his life his application to be placed with his brother was under consideration. This could not be done whilst he was in detoxification. As soon as his release was notified to administrative staff his papers began to be processed. It was the likelihood he would have been placed with his brother within the next few days.

Finding

That [the deceased] died on the 15 April 1999 by hanging at his own hand whilst an inmate at Metropolitan Remand Centre Silverwater in the State of New South Wales.

1122 of 1999

Male aged 19 years died on 5 June 1999 about 10 kilometres west of Parkes. Finding handed down on 24 March 2000 at Parkes by Dr Elwyn Elms, Acting Deputy State Coroner

The deceased was noticed driving dangerously in the main street of Parkes. A private citizen reported this to the police who activated their warning lights and siren, signalled a pursuit and pursued the deceased's vehicle from the town centre, through the residential area of Parkes and thereafter out on the Brolgan Road, where the police came across the deceased's vehicle which had crashed into a tree. The pursuit lasted 11 kilometres.

The circumstances leading up to the pursuit

During the evening of 5 June, the deceased (H) attended a dinner party at his sister's home to celebrate her husband's birthday to. During the evening his de facto wife, N, observed him to drink 4 or 5 bottles of full strength beer (the same size as Light Ice) and a cap full of rum. On one occasion he was observed pouring rum into his beer bottle. Shortly before midnight, the deceased apparently took exception to something N said or did and left the premises.

He was observed exiting from the driveway in his vehicle at 70 kilometres per hour, then slamming on the brakes, locking all four wheels up and skidding about three or four feet. 'When he got past the gutter, he floored the car and sped away'. N described him as driving off at a very fast speed 'doing fishies up the road'. A short time later, he was noticed by Sergeant C travelling at 60 kph in Clarinda Street, not breaking the law but enough to attract Sergeant C's attention because it was unusual for that length of road, being the main street of Parkes.

The deceased's manner of driving also brought him to the attention of Mr.WC, a concerned local citizen who was sitting in his vehicle that was parked on the eastern side of Clarinda near Church Street along with McK. WC saw the vehicle driving up and down Clarinda Street with the engine roaring at about 80 kph, then a short time later fish tailing up the road, 'passing from one side to the other and I would say when he went on to the incorrect side of the road he nearly lost control of the car'. At this point, he was very lucky to control the vehicle and keep it on the road.