CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jonathon Hogan
Hearing dates:	2 to 6 December 2019
Date of findings:	6 May 2020
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, Junee Correctional Centre, mental health treatment in custody, Aboriginal Mental Health Worker
File Number	2018/37983
Representation:	Mr C McGorey, counsel assisting, instructed by Mr J Loosley, Crown Solicitor's Office Ms M Swift for Matt Hogan, instructed by D Evenden and H Cooper, Legal Aid Commission of NSW Mr A Jobe, Department of Communities and Justice, for the Commissioner of Corrective Services NSW Mr B Bradley for the Justice Health and Forensic Mental Health Network, instructed by K Hinchcliffe, Makinson d'Apice Lawyers Ms T Berberian for GEO Group Australia Pty Ltd, instructed by K Lieu, Sparke Helmore Lawyers Ms L McFee for Dr Matthew Jones, instructed by G Peres da Costa, MDA National Insurance Pty Ltd

Non-publication orders:

I make the following orders pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW):

1. The following information contained in the brief of evidence tendered in the proceedings not be published:
    (a) The name and identifying details of Jonathon Hogan's children and partner.
    (b) The names, addresses, phone numbers and other personal information that might identify:
        i. Any member of Mr Hogan's family (save for the name and photograph of Matthew Hogan); and
        ii. Any person who visited Mr Hogan while in custody (other than legal representatives or visitors acting in a professional capacity).
    (c) The names, personal information, Master Index Numbers (MIN) and any other information which may tend to identify any persons in the custody of Corrective Services New South Wales ("CSNSW"), other than Mr Hogan.
    (d) The direct contact details of CSNSW staff not publically available.
    (e) The Junee Correctional Centre daily roster for 3 February 2018.
    (f) The following sections of the Junee Correctional Centre Operating Specifications:
        i. 1.20 – Management of special needs inmates;
        ii. 1.43 – Addressing Offender Behaviour; and
        iii. 1.44 – Offender Services and Programs.
    (g) Extract of the Junee Correctional Centre Policy OP003 – Night Shift – Officers General Duties.
    (h) CSNSW Custodial Operations Policy and Procedures – Section 19.2; Movement Orders and Permits.
    (i) Images and footage taken from CCTV.
    (j) Any schematic design/layout of Junee Correctional Centre.

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Part One

Introduction

1. This inquest concerns the tragic death of Jonathon Hogan. “Jono”, as he was known to his family, was 23 years of age when he died at Junee Correctional Centre (“Junee CC”) on 3 February 2018.

2. Jonathon was a proud indigenous man of the Wiradjuri, Ngiyampaa and Murrawarri people whose lands stretch from around Canberra and up to Brewarrina.[1] His father, Matthew Hogan, spoke during the inquest of Jonathon’s love of the bush – he loved going to the river to swim or fish – and he always preferred to be outside as a child. Jonathon was also a talented artist and I was humbled to have the opportunity to display some examples of his artwork in the courtroom throughout the inquest.

3. Jonathon came from a large extended family including his parents and nine siblings. He is survived by his partner, [redacted] and their five children: [redacted].[2] He is greatly missed by all those who loved and cared for him.

4. Matthew Hogan represented Jonathon’s extended family at the inquest each day. Mr Hogan made it clear that Jonathon loved his family and, equally, his family loved him. He described Jonathon as a “happy-go-lucky kid, always laughing and clowning around”.[3] I thank Mr Hogan for his attendance and patience in such sad circumstances. I am aware that other family members followed the proceedings closely, some even attending the vicinity of the court, with only their terrible sadness preventing them from entering the courtroom.[4]

5. Jonathon was alone when he died. He was subsequently found by correctional staff in his cell. He was hanging by a prison blanket from a bunk bed. Although resuscitation was attempted, it was by then too late to revive him.

6. Jonathon had long-standing and well documented mental health issues. The evidence before this court indicates that the mental health services provided to Jonathon prior to his death were inadequate.

7. Beyond the circumstances of this individual tragedy, the investigation into Jonathon’s death raised broader questions about the general level of care provided to inmates suffering mental illness within our prison system. It also demonstrated that many of the concerns raised

[1] T02.12.19 at 2.31 (Family statement of Matthew Hogan).
[2] Exhibit 1: Volume 1, Tab 8A, Statement of [redacted] dated 11 November 2019.
[3] T06.12.19 at 98.43 (Family statement of Matthew Hogan).
[4] T06.12.19 at 97.30 (Family statement of Matthew Hogan).

during the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), thirty years ago, remain unresolved today.

Background

8. It is necessary to place Jonathon's incarceration in its wider social context prior to a close examination of the particular facts of his death.

9. According to the Australian Law Reform Commission, Aboriginal and Torres Strait Islander adults make up around 2% of the national population, however they constitute around 27% of the national prison population.[5] In 2016, around 20 in every 1000 Aboriginal and Torres Strait Islander people were incarcerated. Tragically, over-representation appears to have grown, not decreased. Aboriginal and Torres Strait Islander incarceration rates increased 41% between 2006 and 2016 and the gap between Aboriginal and Torres Strait Islander and non-Indigenous rates widened over the decade.[6]

10. Specifically in NSW, the Bureau of Crimes Statistics and Research ("BOSCAR") have reported that as at March 2019, 25% of the prison population across the state were identified as indigenous.[7] During the inquest, Junee Correctional Centre also confirmed that its indigenous population sat at around 30% of its total inmate population.[8]

11. The over-representation of Aboriginal and Torres Strait Islander people is hardly a recently discovered phenomenon. Its continued existence was accurately described in one submission to the recent Australian Law Reform Commission's Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander people as a "national disgrace".[9]

12. As far back as 1991, the RCIADIC found that Aboriginal people were grossly over-represented in custody. Further, the Commissioners noted that this over-representation in both police and prison custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody."[10] In other words, until we do something about over-representation, we will certainly continue to record a disproportionate level of indigenous deaths in custody.

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[5] Exhibit 13: ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.
[6] *Ibid,* pp. 21-22.
[7] Exhibit 12: BOSCAR New South Wales Custody Statistics, Quarterly Update (March 2019), p. 25.
[8] T04.12.19 at 82.30 (Wood XN).
[9] Exhibit 13: ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.
[10] Exhibit 13: ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.

13. Almost 30 years after the RCIADIC, we have failed to appropriately reduce the shockingly disproportionate incarceration of indigenous people or to properly grapple with the underlying factors. The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration including: "the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects". The Commission also identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody.[11] Decades later, these factors remain at the forefront of our failure to reduce incarceration rates. Despite attempts to "Close the Gap", disadvantage abounds and successive governments have been unable to squarely face the effects of dispossession and move forward with "truth telling" and agreement with Aboriginal and Torres Strait Islander peoples.[12]

14. It is clear that if we are to reduce the number of Aboriginal deaths in custody we need to grapple with the underlying causes of over-representation. The ALRC report properly supports initiatives such as justice re-investment as one crucial strategy.[13] While it is well beyond the scope of this inquest to suggest other strategies, it is necessary to state clearly the nature of this ongoing problem. Quite simply, more young Aboriginal citizens like Jonathon must be diverted away from the criminal justice system if we are to reduce the number of Aboriginal deaths in custody nationally.

15. It is also relevant to these proceedings that not only are Aboriginal and Torres Strait Islander people over-represented within the prison system, their rate of suicide attempts over a lifetime are significantly higher than those in the non-Aboriginal population. The court was informed that an estimated 33.7% of prisoners in NSW have exhibited suicidal ideation during their lifetime, of which 20.5% report suicide attempts. A significantly greater proportion of Aboriginal inmates (26.9%), compared to non-Aboriginal (18.7%) attempt suicide during their lifetime.[14]

16. It is clear that indigenous prisoners are at greater risk of suicide than their non-indigenous counterparts. Jonathon's personal risk was even higher. He had been diagnosed with schizophrenia and had reported episodes of psychosis characterised by auditory hallucinations. The court heard that inmates with serious mental illnesses are potentially more vulnerable in a correctional setting and may require more assertive monitoring and

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[11] *Ibid*, p. 22.
[12] The importance of initiatives such as the *Uluru Statement from the Heart* cannot be underestimated in this context. Such mechanisms urge us as a country to do better.
[13] Exhibit 13: ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, Recommendations 4-1 and 4-2.
[14] Exhibit 1: Volume 6, Tab 100, FN5 to Report of Dr Kerri Eagle, p. 2226.

treatment to ensure that their mental health needs are addressed.[15] The rate of suicide among prisoners, as compared to the general population is high. Serious mental illness is associated with a significantly elevated risk of suicide amongst inmates.[16]

17. These factors form the relevant background to my specific inquiries. They are worthy of careful consideration. Jonathon's death is not an isolated tragedy caused simply by the particular acts or omissions of any individual. His death is properly understood in its context of social injustice and dispossession.

The role of the coroner

18. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[17] A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[18]

19. In this case there is no dispute in relation to identity or to the date, place or medical cause of death. It was also readily apparent that Jonathon's death, occurring in a locked cell was self-inflicted. For this reason the inquest focussed on the circumstances of Jonathon's death and on questions about whether anything could have been done to prevent it.

20. When a person dies in custody it is mandatory that an inquest is held.[19] The inquest must be conducted by a senior coroner.[20] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate. Their living conditions are similarly restricted and prison authorities are called upon to manage an array of inmates, taking into account their often disparate medical needs and other requirements. Considerations relating to medical care and cell placement are important and can have significant impact on an inmate's state of mind and physical well-being.

21. Jonathon was in custody from 2 August 2017 to 3 February 2018. He entered custody with a clear risk of self-harm. He was a young indigenous man with serious mental health issues.

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[15] Exhibit 1: Volume 6 Tab 100, Report of Dr Kerri Eagle at [100.1], pp. 2165-2166.
[16] Ibid, pp. 2170-2171.
[17] Section 81 *Coroners Act* 2009 (NSW)
[18] Section 82 *Coroners Act* 2009 (NSW)
[19] Section *27 Coroners Act* 2009 (NSW)
[20] Section *24 Coroners Act* 2009 (NSW)

He had previously attempted suicide and committed self-harm on a number of occasions. As we shall see, he was actively withdrawing from drugs, had very significant relationship difficulties and his personality meant that he mostly kept to himself. One of the tasks of this inquest has been to examine what those charged with Jonathon's care ought to have known about his risk of self-harm and suicide, as well as what they actually knew.

22. The court has carefully examined what was done to keep Jonathon safe and found aspects of the care given to him were inadequate. The purpose of the inquest, however, is not to cast blame on specific individuals involved in his care but to identify systemic failings capable of rectification or improvement in the hope of preventing or reducing the possibility of future tragedies of this kind.

23. The pain felt by Jonathon's family and the broader Aboriginal community is profound and ongoing. His story will affect the lives of his children and his community well into the future. Each successive Aboriginal suicide in custody shapes the story younger prisoners learn when they too are incarcerated. Tragically, the despair felt by Jonathon may well have been transitory. There needed to be stronger, culturally appropriate safeguards in place to identify his needs at an earlier time.

24. It was clear to me that Matthew Hogan's participation in these proceedings was directed towards more than understanding the causes of his own son's death but also to identifying opportunities for change that could assist others. I acknowledge his dignity and generosity in participating in these proceedings and I thank him for his significant contribution.

The evidence

25. The court took evidence over five hearing days, The court also received extensive documentary material, comprising six volumes. This material included: witness statements, medical and custodial records, investigation reports, recordings and photographs. The court heard oral evidence from doctors, nurses and correctional staff who cared for Jonathon and was assisted by the expert evidence of Dr Kerri Eagle, a forensic psychiatrist who undertook an independent review of Jonathon's mental health care and treatment in custody. While I do not intend to refer specifically to all the available material in detail in these findings, it has been comprehensively reviewed and assessed.

26. I should note that while the court was aware of Jonathon's contact with mental health services in the ACT just prior to his incarceration in NSW that contact was beyond the scope of this inquiry.

27. A list of issues was prepared before the proceedings commenced.[21] These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons fairly briefly under a small number of broad headings.

28. The focus of the inquest ultimately centred on the systemic challenges, rather than judging the conduct of specific individuals involved in the provision of health or custodial services. At the end of the day, while no individual is singled out for particular criticism, some of the systems in place at the time of Jonoathon's's death were exposed as in need of review and improvement. Once again this court is faced with assessing care given by individuals within a system that is seriously under-resourced.

Fact finding

29. Those assisting me prepared a concise summary of the extensive documentary evidence obtained in relation to Jonoathon's death.[22] The summary was circulated to the interested parties during the course of the inquest for consideration and comment, prior to finalisation. The summary was a careful synopsis of the salient facts leading up to Jonathon's death. I indicated to the interested parties that I intended to adopt it as the basis of my fact finding and urged comment or correction. I was alerted to no particular controversy. In my view what follows is an accurate and useful distillation of the tendered material. I thank those assisting me for their hard work in the preparation of the following chronology.

Part two

Chronology

Personal Background

30. Jonathon was born in Canberra on 28 July 1994. He was the fifth of ten children born to Matthew Hogan and [redacted].[23]

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[21] The list of issues considered during the inquest included as follows:
(i) The adequacy of medical screening conducted of Mr Hogan when he entered custody at Junee Correctional Centre on 2 August 2017.
(ii) The adequacy and timeliness of psychiatric and/or nursing reviews (including but not limited to the administration of medication) conducted of Mr Hogan while he was incarcerated at Junee Correctional Centre.
(iii) The adequacy and availability of Mr Hogan's clinical documentation.
(iv) Whether orders for Mr Hogan's assessment under the *Mental Health (Forensic Provisions) Act 1990* were appropriately actioned by staff at Junee Correctional Centre.
(v) The appropriateness of Mr Hogan's cell placement at the time of his death.
(vi) The adequacy and appropriateness of the response by Correctional Officers following the discovery of Mr Hogan on the evening of 3 February 2018.

[22] I thank Christopher McGorey and James Loosley for their hard work in this regard.

[23] Exhibit 1: Vol 1, Tab 8, Statement of Matthew Hogan dated 11 October 2018, p. 67.

31. Jonathon's childhood was fairly typical until around 14 years of age, when he experienced difficulties with alcohol and marijuana.[24]

32. In 2008 Jonathon met [redacted] whilst detained in the Quamby Youth Detention Centre in the ACT.[25]

33. In 2011 Jonathon and [redacted] started a relationship.[26] They eventually had five children together; with the youngest born in November 2017 while Jonathon was in custody.[27]

34. Their children were placed into the care of other family members by the Department of Family and Community Services due to substance abuse and other difficulties.[28]

35. By around 2010, aged about 18 years, Jonathon had commenced using methamphetamine, initially by smoking and proceeding to intravenous use by age 19.[29]

36. He came into the increasing attention of police for property, drug and other offences. His offending was primarily drug related. This resulted in increasing periods of incarceration whether on remand or as a sentenced prisoner.

Mental Health History

37. Jonathon had a history of interaction with mental health services in NSW and the ACT.

38. On 22 February 2013, while on remand at the Alexander Maconochie Centre in the ACT, Jonathon swallowed a fragment of a razor blade.[30]

39. On 28 February 2013, Jonathon was admitted as a voluntary patient in the Adult Mental Health Unit ("AMHU") at Canberra Hospital. The Psychiatric Registrar noted the incident was Jonathon's first episode of psychosis with distressing auditory hallucinations (voices yelling and telling him to harm himself) and strong suicidal ideation.[31]

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[24] *Ibid*, p. 68.
[25] Exhibit 1: Vol 1, Tab 8A, Statement of [redacted] dated 11 November 2019, p. 71.1.
[26] *Ibid*, p. 71.2.
[27] *Ibid*, p. 71.5.
[28] *Ibid*, p. 71.4.
[29] Exhibit 1: Vol 5, Tab 90, Medical File, pp. 1216-1217.
[30] Exhibit 1: Vol 5, Tab 94, Records from 2013 admission at the Canberra Hospital, pp. 1791-1792.
[31] Exhibit 1: Vol 4, Tab 90, Canberra Hospital Adult MH Unit Discharge Summary dated 10 March 2014, p. 1157.

40. On 8 March 2013, Jonathon absconded from the AMHU after being granted bail. A discharge report noted Jonathon had been known to the Forensic Mental Health team since 2007.[32]

41. In about 2014, Jonathon and [redacted] methamphetamine use worsened.[33]

42. On 24 August 2014, while on remand at the Wellington Correctional Centre, he attempted self-harm (cut to arm). Jonathon also reported that he had attempted to hang himself a week earlier (out of custody) but had been interrupted by a neighbour.[34]

43. On 26 August 2014, Jonathon was reviewed in custody by a psychiatrist, Dr Cocks, who formed the impression he suffered from paranoid schizophrenia and polysubstance dependence.[35]

44. On 28 July 2015, after entering Parklea Correctional Centre, he was noted to have a history of schizophrenia and self-harm. He had been prescribed Olanzapine (antipsychotic) medication after being released in August 2014. He reported not having seen a doctor since then and having substituted illicit substances for his medication. During the prior four months he reported using methamphetamine daily.[36]

45. On 8 August 2015, Jonathon was found eligible to participate in the Drug Court program.[37]

46. On 24 August 2015, Jonathon was assessed by Dr Gregory Hugh (psychiatrist), Drug Court Assessment Unit, who noted Jonathon's drug use and that he had tried buprenorphine in custody. Jonathon reported a several year history of auditory hallucinations, which included derogatory voices that told him to hurt himself (cutting or hanging).[38]

47. On 2 September 2015, Jonathon was released from custody to commence the Drug Court program while residing in the community and attended regular counselling and drug screens.

48. On 6 March 2016, Jonathon was arrested and charged with offending on [redacted] During a mental health assessment on 7 March 2016 he reported himself and his partner had 'binged' on 'ice' over the preceding three days and being non-compliant with his Olanzapine

[32] Exhibit 1: Vol 5, Tab 94, Records from 2013 admission at the Canberra Hospital, pp. 1791-1792.
[33] Exhibit 1: Vol 1, Tab 8A, Statement of [redacted] dated 11 November 2019.
[34] Exhibit 1: Vol 5, Tab 90, Medical File, pp. 1137, 1160.
[35] Exhibit 1: Vol 5, Tab 90, Medical File, p. 1138.
[36] Exhibit 1: Vol 4, Tab 90, Justice Health Progress Note, p. 1122.
[37] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, pp. 572-573.
[38] Exhibit 1: Vol 4, Tab 90, Drug Court Assessment Report, pp. 1216-1217.

medication.[39] He returned to custody following his arrest where he remained until his release to parole on 11 November 2016.

49. On 29 March 2016, Jonathon's participation in the Drug Court program was terminated after he was charged with a new offence.[40]

50. On 27 July 2016, Jonathon reported to Correctional staff he was hearing voices. He denied thoughts of self-harm but stated: "*I might do something silly as I can access razors in the cell"* and *"I'm stressed out*" and the voices are there most of the time.[41] It was noted he had only recently recommenced antipsychotic medication and he was managed by the Risk Intervention Team for a period of time.[42]

51. On 1 August 2016, Jonathon was reviewed by Dr Sunny Wade (psychiatrist) while he was detained for treatment in the Darcy Pod at the Metropolitan Remand and Reception Centre ("MRRC"). Dr Wade formed the impression that Jonathon was suffering from schizophrenia and substance use disorder.[43] Dr Wade cleared Jonathon for normal cell placement.[44]

52. On 23 August 2016, Jonathon reported to the medical clinic at MRRC that he had swallowed razor blades and he was hearing voices yelling to "get up". He also reported his medication wasn't working but later admitted he had been diverting his medication.'[45]

53. On 11 November 2016, Jonathon was released to parole. On release he was prescribed Zyprexa for treatment of his schizophrenia and an antidepressant (Alexapro) for depression.[46]

No-contact AVO

54. On 19 April 2017, the Downing Centre Local Court made a 12-month no contact apprehended violence order ("AVO") against Jonathon for the protection of [redacted] This was on the application of police and followed an alleged contravention of an earlier made on 20 March 2017.

ACT Mental Health Admission

[39] Exhibit 1: Vol 4, Tab 91, MHOAT dated 7 March 2016, p. 1286.
[40] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, pp. 572-573.
[41] Exhibit 1: Vol 4, Tab 90, Justice Health Progress Note dated 27 July 2016, p. 1283.
[42] Exhibit 1: Vol 5, Tab 92, MRRC RIT Case Note dated 29 July 2016, p. 1528.
[43] Exhibit 1: Vol 5, Tab 92, Medical File, pp. 1535-1540.
[44] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note dated 1 August 2016, pp. 1535-1540.
[45] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note dated 24 August 2016, p.1544
[46] Exhibit 1: Vol 5, Tab 92, Connections Program Assessment Form, p. 1562.

55. On 28 July 2017, Jonathon was charged with additional offences and was bail refused in the ACT in relation to an outstanding warrant and other offences.[47]

56. On 29 July 2017, Jonathon was transferred to Canberra Hospital for mental health assessment under an order issued by the ACT Children's Court pursuant to s. 309 of the *Crimes Act 1900* (ACT).[48] Jonathon presented as distressed and reported that he had been experiencing auditory hallucinations since 2012. He reported '*Significant methamphetamine use*' the preceding day (about 8 points).[49] Jonathon absconded from the hospital that evening.

Alleged offences in NSW between 31 July and 1 August 2017

57. On about 31 July 2017, Jonathon and [redacted] travelled in a car to Orange, NSW.

58. Between 31 July 2017 and 1 August 2017, Jonathon and [redacted] allegedly committed several property offences in Orange. Police allegedly pursued Jonathon in his vehicle several times before his vehicle was stopped and he and [redacted] were apprehended at about 2 pm on 1 August 2017 near Boorowa, NSW. [50]

59. Jonathon was arrested, charged and bail refused at Cootamundra Police Station in relation to an outstanding breach of parole warrant and other fresh offences.[51]

60. In an interview with police officers, Jonathon said he had no memory of any of the incidents or a large part of the previous five months. He stated he had not used his medication and was suffering from mental health problems.[52] A Custody Management Record completed while he was at the police station also recorded: "…*The person is getting very agitated in the dock and is punching the dock door. States he suffers from mental illness and hallucinates."*[53]

61. A parole warrant directed the parole order be treated as having been revoked on 19 April 2016. Jonathon had a balance of parole to be served of five months and 23 days, expiring on 23 January 2018.[54]

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[47] Exhibit 1: Vol 2, Tab 33, Police Facts Sheet H65927042, p. 429.
[48] Exhibit 1: Vol 5, Tab 96, Canberra Hospital 2017 admission records, pp. 1893-1903.
[49] Exhibit 1: Vol 5, Tab 96, ACT Health Consult Referral Form dated 29 July 2017, p.1898.
[50] Exhibit 1: Vol 2, Tab 33, Police Facts Sheet H65927042, p. 429.
[51] Exhibit 1: Vol 2, Tab 36, Criminal History – Bail Report, pp. 459-460; Vol 2, Tab 44, Case Management File, p. 671; Vol 3, Tab 45, Warrant File, pp. 815-816.
[52] Exhibit 1: Vol 2, Tab 33, Police Facts Sheet H65927042, p. 429.
[53] Exhibit 1: Vol 2, Tab 44, Custody Management Record dated 2 August 2017, p. 686.
[54] Exhibit 1: Vol 3, Tab 45, Warrant File, p. 742.

62. At 1:40am on 2 August 2017, a New Inmate Identification and Observation Form was completed about Jonathon at Wagga Wagga. The Form noted that Jonathon suffered from schizophrenia but had not taken his medication "for several months". Jonathon also reported smoking cannabis the day prior and using methamphetamine two days prior.[55]

63. At 11:49am on 2 August 2017, Jonathon's criminal matters were mentioned before the Registrar at Wagga Wagga Local Court. No bail application was made on Jonathon's behalf and bail was formally refused by the Registrar; with the matters adjourned and listed before Young Local Court on 8 August 2017.[56]

Admission at Junee Correctional Centre

64. On 2 August 2017, Jonathon was admitted to the Junee CC in Junee, about 40 kilometres from Wagga Wagga.

Junee Correctional Centre

65. Junee CC is a declared correctional centre for the purposes of s. 225 of the *Crimes (Administration of Sentences) Act 1999* ("the CAS Act").

66. It was originally built in 1993 by the GEO Group Australia Pty Ltd ("GEO Group"). The GEO Group has operated Junee CC since its construction.[57]

67. GEO Group as operator of the Junee CC was responsible for the provision and coordination of health services at Junee CC. This was under the *Management Agreement for Junee Correctional Centre* (2009) as between the Commissioner for Corrective Services NSW and the GEO Group.[58]

68. As operator the GEO Group must permit the Justice Health and Forensic Mental Health Network ("Justice Health") free and unfettered access to all parts of the Junee CC and records in relation to Health Services provided in the Junee CC to all inmates.[59] Justice Health monitors the provision of health services in managed correctional centres including the Junee CC.[60]

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[55] Exhibit 1: Vol 2, Tab 44, Case Management File, pp. 672-677.
[56] Exhibit 1: Vol 2, Tab 22, Wagga Wagga LC Transcript, pp. 388-389.
[57] Exhibit 1: Vol 1, Tab 19B, Statement of Terrence Murrell dated 11 October 2019, p. 187.2
[58] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [8], p. 199.
[59] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [11], p. 200; *Crimes (Administration of Sentences) Act 1999* s. 244.
[60] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [12], p. 200; *Crimes (Administration of Sentences) Act 1999* s. 236A(b).

69. The GEO Group is required, as part of its health service obligations, to provide mental health services under the protocols of the Statewide Forensic Mental Health Service and adhere to Justice Health's policies, procedures and guidelines and to ensure its policies and procedures are consistent with those of Justice Health.[61]

70. That includes the Custodial Mental Health Operational Procedure Manual ("CMH manual").[62] The CMH manual sets out the operational framework and procedures for Custodial Mental Health. It is intended as a resource for Justice Health staff working within correctional centres.[63]

71. The scheduling of medical reviews of inmates is managed by way of an electronic Patient Administration System ("PAS"). The CMH manual provides a PAS Waiting List Priority Level Protocol for mental health. This guides the prioritisation of patient booking according to their clinical needs.[64]

72. As at 2017, Justice Health maintained the following records for inmate patients:

    (a) an electronic records system for inmates known as the Justice Health electronic Health System ("JHeHS").[65] The system recorded for each inmate relevant alerts (e.g. whether a patient had self-harmed). It also allowed for reports, clinical correspondence and other medical records to be uploaded into the electronic record. Those records could then be accessed and downloaded by staff with access to the system; and

    (b) patient files which contained hard copies of progress notes, reports and other records for the patient.

73. During the hearing a screenshot of Jonathon's JHeHS record was tendered.[66]

74. Dr Sarah-Jane Spencer, the Clinical Director of Custodial Mental Health and Co-Director (Clinical) Services and Programs within Justice Health, gave evidence about JHeHS during the inquest. Dr Spencer described JHeHS as a relatively unique and evolving system that had been designed specifically for Justice Health. Dr Spencer said that JHeHS allowed for

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[61] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [15]-[16], p. 200.
[62] Exhibit 1: Vol 1, Tab 21, CMH Manual (Annexure E to statement of Dr Sarah-Jane Spencer dated 6 August 2019), p. 251.
[63] Exhibit 1: Vol 1, Tab 21, CMH Manual (Annexure E to statement of Dr Sarah-Jane Spencer dated 6 August 2019), p. 256.
[64] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [28], p. 200. Triage categories are 'urgent' (seen 1-3 days), 'semi urgent' (seen 3-14 days), 'non-urgent' (seen 14 to 90 days' and 'routine' (within 12 months); see also Justice Health Custodial Mental Health Operational Procedure Manual (Annexure E to statement of Dr Sarah-Jane Spencer dated 6 August 2019), p. 266-267.
[65] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 28 May 2019 at [2], p. 80.
[66] Exhibit 6: JHeHS electronic screenshot.

different medical reports to be uploaded to a patient's electronic file, which could be viewed by a treating physician. Dr Spencer also confirmed that as at 3 December 2019, Justice Health was transitioning to electronic progress notes that would also be stored in JHeHS.[67]

75. Junee CC medical staff, employed by GEO Group, had access to the patient files and JHeHS maintained by Justice Health for patients at Junee CC.

Mental health clinicians at the Junee CC

76. The Junee CC provided mental health treatment to inmates but did not contain a declared mental health facility within its grounds. Junee CC employed or contracted staff for the provision of medical treatment including:

    (a) Dr Darren Corbett as General Practitioner ("GP").

    (b) RN Alexander Tobin, a Registered Nurse ("RN") ("Tobin RN")**.**

    (c) Dr Matthew Jones (psychiatrist), a Visiting Medical Officer ("VMO"), who usually attended two consecutive days each fortnight (Wednesday-Thursday).

77. As at August 2017, there were two nurses at Junee CC assigned to mental health, namely: Tobin RN and RN Julie Anne Williams ("Williams RN").[68]

78. Sentenced inmates considered 'mentally ill'[69] can also be transferred in custody from Junee CC to specialist placements (declared mental health facilities)[70] within Correctional Centres, for mental health treatment such as:

    (a) Mental Health Screening Unit ("MHSU") for males in the MRRC;

    (b) Place of Detention ("POD") 17 and 18, Hamden Block within the MRRC; or

    (c) the Mental Health Unit, Long Bay Hospital.

79. That could be done under the exercise of power pursuant s. 55 of the *Mental Health (Forensic Provision) Act 1990* ("the MHFP Act") or by other order.

80. Management of bed availability for the POD and the Mental Health Screening Unit ("MHSU") is discussed at weekly meetings which include GEO Group staff participation.[71]

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[67] T02.12.19 at 85.35-50 (Spencer XN).
[68] T03.12.19 at 43.20-44 (Tobin RN XN).
[69] 'Mentally ill' as defined in the *Mental Health Act 2007.*
[70] Declared under s. 109 of the *Mental Health Act 2007.*
[71] Exhibit 1: Vol 1, Tab 21, Statement of Dr Sarah-Jane Spencer dated 6 August 2019 at [26]-[27], p. 202.

RAPO, Aboriginal Health Worker and Cultural Advisor

81. Presently, the GEO Group does not employ any person in the position of Aboriginal Health Worker at Junee CC.

82. Corrective Services NSW ("CSNSW") employs Geoffrey McAdam as a Regional Aboriginal Project Officer ("RAPO") for the south-west region of NSW. In that capacity, Mr McAdam attends 17 correctional centres from Cooma through to Broken Hill. He typically visits each centre at least once per month.[72] There are four RAPOs in New South Wales. Mr McAdam's role includes meeting with delegates of the Aboriginal Inmate Delegate Committee ("AIDC"). He also assists aboriginal inmates who are moved from one centre to another and when they are released from custody including assistance in gaining employment or training.[73]

83. In 2017 and now, GEO Group employs a person in the role of Cultural Advisor based at the Junee CC. In 2017, Gerome Brodin carried out this role. Mr Brodin previously worked as a correctional officer with GEO Group. His role involved organising cultural activities and cultural days at Junrr CC including for NAIDOC week, Ramadan, Eid festival, Chinese New Year, Anzac Day, and Remembrance Day. Mr Brodin also arranged for the provision of paints and canvases for inmates. Mr Brodin also engaged with the AIDC, which was constituted by inmate delegates from each unit and met about twice per month to discuss any concerns raised by the Committee. Mr Brodin's role is not principally about one to one contact with inmates, although that sometimes occurs in the course of arranging activities.[74]

Assessment on admission to Junee CC on 2 August 2017

84. On 2 August 2017, a Reception Screening Assessment ("RSA") and Health Problem Notification Form ("HPNF") was completed for Jonathon by RN Tegan Aylward ("Aylward RN").[75]

85. The RSA and HPNF are electronic screening tools used by Justice Health. Information captured during screening is entered into JHeHS.[76]

86. Aylward RN was employed as a registered nurse by the GEO Group to work at the Junee CC.

87. On 2 August 2017, Aylward RN was working in the role of "intake nurse" at Junee CC.

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[72] T05.12.19 at 44.12 (McAdam XN).
[73] T05.12.19 at 46 (McAdam XN).
[74] T05.12.19 at 2-3.
[75] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1762-1771.
[76] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 28 May 2019 at [2], p. 80.

88. Aylward RN carried out a face to face assessment of Jonathon in a private room in the intake area.[77] She asked him a series of questions and made observations of him. She recorded information she considered to be relevant in a handwritten progress note[78] and also in the electronic RSA and HPNF.

89. Aylward RN was not medically trained or responsible for making diagnoses for patients; only to record clinical observations and nursing opinions in the RSA.[79]

90. The RSA completed by Aylward RN relevantly noted:[80]

    (a) Jonathon had several existing health conditions including depression and paranoid schizophrenia (since age 17);

    (b) Jonathon had previous contact with Canberra Hospital regarding mental health concerns;

    (c) Jonathon had been using six-points of methamphetamine daily (IV, smoked) and smoked '10 cones' of cannabis daily before his return to custody;

    (d) Clinician assessment of patient presentation: "In withdrawal";

    (e) Patient presentation (Mental Health perspective): "*pt co-operative, slightly restless, unable to sit still*";

    (f) Mental Health Condition: 'depression, schizophrenia';

    (g) Last attempted self-harm: '*many years ago'* by '*cutting'*; and

    (h) Jonathon had responded "*yeah good*" when asked how he thought he would cope in prison.

91. The HPNF relevantly noted:[81]

    (a) Jonathon had some mental health issues – observe for mood swings;

    (b) there had been observed agitation, isolative/inappropriate behaviour;

    (c) he had a history of substance abuse (was to be observed for nausea, vomiting, hallucinations, seizures); and

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[77] T03.12.2019 at 77.46.
[78] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note dated 2 August 2017, p. 1608.
[79] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 28 May 2019 at [9], p. 81.
[80] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1762-1771.
[81] Exhibit 1: Vol 5, Tab 92, HPNF, p. 1589

(d) he had 'special health needs' to be addressed by a "two-out" cell placement for two weeks (to expire on 16 August 2017) followed by a normal cell placement with contact to be made to medical if concerns arose.

92. The progress note completed by Aylward RN relevantly noted:[82]

(a) Jonathon was previously on "*meds for depression + schizophrenia*";

(b) "…*cooperative, good eye contact*…";

(c) "…*use ice (IV + smoked) daily – 6 points + cannabis daily. Commenced on withdrawal monitoring + nurse initiated Phenergan for 7 days*";

(d) "…*Reports poor memory of yesterday's events, however also states he took a pill from a friend a few days ago + has felt vague since then*…"; and

(e) "*Nil current meds, no community mental health provider"*.

93. Aylward RN referred Jonathon to the Mental Health Nurse and Drug and Alcohol Nurse for assessment.[83]

94. Junee CC had a standing order that 50mg Promethazine (also known as Phenergan, antihistamine) be prescribed (night-time) for seven days to assist patients withdrawing from methamphetamine use.[84] Jonathon was prescribed the same.

95. During induction at Junee CC, Aylward RN had been advised that new receptions of inmates at risk of withdrawing from drugs or alcohol, or with mental health issues, were to be placed in a "two-out" cell placement for their first two weeks in custody.

96. The initial "two-out" cell placement permitted the inmate time to settle in the facility, undergo some detoxification and have someone else present in their cell to call for help if necessary. The expectation is that the inmate will be reviewed within that period by speciality nurses and/or the GP.[85]

97. Aylward RN, as reception nurse, was not responsible for booking or managing the inmate's medical reviews. Once placed on a wait list for referral to specialised nurses, those speciality nurses made and managed their own appointments.

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[82] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note dated 2 August 2017, p. 1608.
[83] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1762-1771.
[84] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 19 May 2019 at [10], p. 81
[85] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 19 May 2019 at [12]-[13], pp.81-82.

98. During Aylward RN's reception review with Jonathon, release of information consent forms were not signed by him. Such forms can obtain information from Community Health providers. The reason for this form not being signed was not documented.

99. Aylward RN's referral to the Mental Health Nurse and Drug and Alcohol Nurse was made via the PAS.[86] Referrals are given a priority classification by the intake nurse. Aylward RN assigned those referrals a 'category 2' classification which indicated Jonathon was to be reviewed within 14 days.[87]

Screening during 3 August 2017

100. On 3 August 2017, an Intake Screening Questionnaire ("ISQ") was completed about Jonathon by Kerri Lee Walker. The ISQ relevantly noted that Jonathon was diagnosed with schizophrenia and had not been taking medication "*for about a year*". Jonathon also reported that he had no contact with his family due to his drug use and indicated that [redacted] remained his only support in the community.[88]

101. On 3 August 2017, a remand reception committee form was completed which noted Jonathon as being an 'un-medicated schizophrenic' and an *immediate safety concern*.[89]

102. On 4 August 2017, Jonathon's classification was approved as "B Medium". The approval form noted: "*Two-out cell placement 01/09/17. History of Self Harm Incident. History of Mental Illness – Schizophrenia*".[90] That same day Jonathon was assessed by a Drug and Alcohol Nurse. Jonathon was noted to be in withdrawal from methamphetamine and cannabis use and prescribed Phenergan.[91]

Court ordered mental health assessment on 8 August 2017

103. On 8 August 2017, Jonathon appeared by audio-visual link ("AVL") before Magistrate O'Brien at Young Local Court. Magistrate O'Brien ordered Jonathon undergo a psychiatric assessment to determine if he was suffering a mental illness and whether there were reasonable grounds to believe him to be a 'mentally ill person' within the meaning of the *Mental Health Act 2007* ("the MH Act"). Jonathon's criminal matters were adjourned until 19 September 2017 to await that assessment.[92]

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[86] T03.12.19 at 44.50 (Tobin RN XN).
[87] T06.12.19 at 90.26-27.
[88] Exhibit 1: Vol 3, Tab 46, Intake Screening Questionnaire, pp. 817-825.
[89] Exhibit 1: Vol 6, Tab 100, Report of Dr Kerri Eagle, p. 2153.
[90] Exhibit 1: Vol 2, Tab 44, Case Management File, pp. 634-637.
[91] Exhibit 1: Vol 5, Tab 92, Medical File, p. 1608.
[92] Exhibit 1: Vol 2, Tab 29, Young LC Transcript, pp. 415-418.

104. By s. 3 of the MH Act, "mental illness" is defined:

> "***mental illness*** means a condition *that seriously impairs*, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions,
>
> (b) hallucinations,
>
> (c) serious disorder of thought form,
>
> (d) a severe disturbance of mood,
>
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d)." (emphasis added)

105. Section 14 of the MH Act provides:

> **"14 Mentally ill persons**
>
> (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
>
> (a) for the person's own protection from serious harm, or
>
> (b) for the protection of others from serious harm.
>
> (2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

106. As at 2017, an employee with the Forensic Mental Health Liaison Officer, Justice Health, would email a request for a Junee CC inmate to be assessed and a report to be prepared to the Junee CC mental health team.[93] Such emails would be sent to the Health Services Management at Junee CC, Jan Te Maru, and one or both of the Mental Health Nurses (Williams RN and Tobin RN).

107. Dr Jones was expected to carry out assessments and provide reports, pursuant to orders of the Court, if requested by GEO Group to do so.[94] The reason why Dr Jones was not requested to prepare the report requested by Magistrate O'Brien with respect to Jonathon is not known.

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[93] T04.12.19 at 51.12 (Te Maru XN)
[94] T04.12.19 at 21 and 50 (Te Maru XN).

Classification change on 17 August 2017

108. On 17 August 2017, Jonathon's security classification was downgraded to "B". The approval form noted Jonathon should maintain contact with psychology and the mental health team when required.[95]

Mental health review by Tobin RN on 24 August 2017

109. On 24 August 2017, Jonathon was reviewed Tobin RN who documented:[96]

    (a) Jonathon reported feeling paranoid, thought people talking about him and sought medication for symptoms ("*I think I might need medication"*);

    (b) Jonathon reported not being subject to community health interventions but thought he may have been in an inpatient unit in the ACT before coming to Junee but was "unsure what for";

    (c) he presented with normal speech flow, logical but vague in conversation, and was orientated to time; and

    (d) he did not have thoughts of harm to self but reported hearing "voices" with people talking about him.

110. Following a discussion with the GP, Jonathon was commenced on Olanzapine 10mg (twice daily) and scheduled for review with Dr Jones the following week. He was also placed on the Metabolic Monitoring List for routine monitoring of the weight of inmates receiving antipsychotic medication.[97]

111. As at 28 August 2017, Jonathon was administered Olanzapine at 10 am and 3 pm under the supervision of nursing staff. Owing to the drowsy effects of the medication when taken at 3pm, Dr Corbett authorised Jonathon receiving his afternoon dose at 3pm to take at night-time (unsupervised) so as not to disrupt his sleeping pattern.[98]

First psychiatric review by Dr Jones on 30 August 2017

112. On 30 August 2017, Jonathon was reviewed by Dr Jones. Dr Jones documented Jonathon:[99]

    (a) had lapses with medication before incarceration but now on Olanzapine;

    (b) reported not using drugs other than small amounts of cannabis;

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[95] Exhibit 1: Vol 2, Tab 44, Case Management File, pp. 633.
[96] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note, p. 1609.
[97] Exhibit 2: GEO Group Investigation Report at [6.21]; Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note, p. 1609.
[98] Exhibit 1: Vol 1, Tab 15, Statement of Dr Darren Corbett, p. 93.3.
[99] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note, pp. 1609-10.

(c) reported hearing voices "and stuff" and symptoms worse when not on medication;

(d) reported "…been missing am Olanz dose – not getting up";

(e) had participated in Adult Drug Court Program previously and would like to undertake drug rehabilitation now.

113. Dr Jones also noted that Jonathon did not talk to anyone except "*my girl (not family, not friends)*".

114. Based on his history and mental state examination, Dr Jones formed the impression that Jonathon had a diagnosis of schizophrenia. Dr Jones altered Jonathon's prescription of Olanzapine to a 20mg nightly dose. The documented plan was for Jonathon to be reviewed in two weeks' time (i.e. around 13 September 2017).[100]

115. On 31 August 2017, Jonathon was seen by the GP, Dr Darren Corbett, to discuss his medications. During that consultation, Dr Corbett reinforced the clinical decisions of Dr Jones the previous day.[101]

Dr Gerald Chew psychiatric review at the MRRC on 8 September 2017

116. Between 6 and 7 September 2017, Jonathon was transferred from Junee CC to the MRRC in Sydney. This was for the purpose of him undergoing psychiatric assessment as ordered.

117. On 8 September 2017, Jonathon was assessed by Dr Gerald Chew at the MRRC.[102] Dr Chew had regard to the recent NSW Police Facts sheet (for the alleged offences on 31 July to 1 August 2017), Jonathon's criminal history and accessed records held by Justice Health which included information about Jonathon's polysubstance abuse and prior psychiatric admissions and reviews.

Transfer back to Junee CC on 10 September 2017

118. On 10 September 2017, Jonathon was transferred back to Junee CC via Bathurst Correctional Centre ("Bathurst CC"). That same day, on 10 September 2017, a second HPNF was completed by RN Alisha Girdlestone noting Jonathon had "nil acute medical concerns" and recommending him for normal cell placement.[103]

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[100] Exhibit 1: Vol 1, Tab 17, Statement of Dr Matthew Jones, pp. 94.1-94.7.
[101] Exhibit 1: Vol 1, Tab 15, Statement of Dr Darren Corbett, pp. 93.1-93.2.
[102] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1778-1782.
[103] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, p. 608; Vol 5, Tab 92, Medical File, p. 1590.

119. On 12 September 2017, Jonathon was transferred to Wagga Wagga Police Station and charged with further offences. The Custody Management Record noted that Jonathon had schizophrenia and had not taken medication for two weeks.[104]

Hard copy patient files

120. On 9 September 2017, a Transfer in and out form (Justice Health) was completed for Jonathon's transfer from MRRC. It noted regarding "All Health Record Volumes – *'Vol 1 (closed)?' and '1 x med chart* and *'3V"'.*[105]

121. During the inquest, Justice Health produced a log that electronically recorded the movements of three volumes of hard copy patient records for Jonathon. In summary the log records:

    (a) the files were transferred by Justice Health to the Junee CC medical clinic by 7 August 2017 (following Jonathon's placement there on 2 August 2017);

    (b) the files were later transferred to the MRRC in early September 2017 for Dr Chew's assessment; and

    (c) the files were transferred back to the Junee CC Clinic on or by 27 September 2017.[106]

Dr Chew's report completed and uploaded to JHeHS on 14-15 September 2017

122. In a report dated 14 September 2017, Dr Chew noted Jonathon's report of auditory hallucinations that were "*much muffled"* on Olanzapine. He was oriented to time, place and person. He said his mood was "*okay*" and there were no overt signs of delusions.

123. Dr Chew diagnosed Jonathon with schizophrenia and opined that he remained "*acutely psychotic despite treatment with antipsychotics*" although on Jonathon's account he was much improved as compared to when he was first incarcerated. Multiple risk issues were noted in his history including self-harm attempts.

124. Dr Chew considered Jonathon was a "*mentally ill person"*. Dr Chew considered Jonathon could be managed in a gazetted mental health unit under s. 33 of the MHFP Act.[107]

125. Dr Chew's report was uploaded into the JHeHS electronic record for Jonathon on or by 15 September 2017.[108] Other reports including those prepared by Statewide Forensic

[104] Exhibit 1: Vol 3, Tab 45, Warrant File, pp. 802-803; Vol 2, Tab 34, Custody Management Record, pp. 436-444.
[105] Exhibit 1: Vol 5, Tab 92, Justice Health Transfer In and Out Form dated 9 September 2017, p. 1592.
[106] Exhibit 11: Patient Health System Record; T05.12.19 at 82.
[107] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1778-1782.

Mental Health Services, and other records, were stored on JHeHS which was accessible to Justice Health nurses, medical officers and authorised clinicians within Junee CC.[109]

126. It was subsequently determined by GEO Group that a hardcopy of Dr Chew's report was not on the patient files held at Junee CC at the time of Jonathon's death[110].

Section 33(1)(b) order made on 19 September 2017

127. On 19 September 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court. Having regard to the report prepared by Dr Chew, an order was made under s. 33(1)(b) of the MHFP Act requiring Jonathon to be taken to a mental health facility.[111]

128. The order was made while Jonathon's pending criminal matters were before the Court (for which he had been remanded). No reference was made to the fact of Jonathon being a sentenced prisoner serving his outstanding balance of parole. During the proceedings, mention was made about Jonathon being taken to Gissing House, a mental health unit within the Wagga Wagga Hospital, for assessment.

129. Section 33(1)-(1B) of the MHFP Act provided:

> '**33 Mentally ill persons**
>
> (1) If, at the commencement or at any time during the course of the hearing of proceedings before a Magistrate, it appears to the Magistrate that the defendant is a mentally ill person, the Magistrate (without derogating from any other order the Magistrate may make in relation to the defendant, whether by way of adjournment, the granting of bail in accordance with the *Bail Act 2013* or otherwise):
>
> (a) may order that the defendant be taken to, and detained in, a mental health facility for assessment, or
>
> (b) may order that the defendant be taken to, and detained in, a mental health facility for assessment and that, if the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, the defendant be brought back before a Magistrate or an authorised officer unless granted bail by a police officer at that facility, or
>
> (c) may discharge the defendant, unconditionally or subject to conditions, into the care of a responsible person.

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[108] Exhibit 9: Email re date of upload of Dr Chew's report; T03.12.19 at 28-29.
[109] Exhibit 6: JHeHS electronic screenshot.
[110] Exhibit 16: Email from Juliann Williams (GEO Group) to Christine Muller (Justice Health) dated 16 July 2018 re location of Dr Chew's report.
[111] Exhibit 1: Vol 2, Tab 29, Young LC Transcript, pp. 419-423; Vol 3, Tab 45, Order for Assessment, p. 780.

(1B) The provisions of the *Mental Health Act 2007* (other than section 51 (1) and (2)) apply to and in respect of the defendant and that order as if the order had been made by the Tribunal under that Act.

(1C) A Magistrate must, before making an order under subsection (1A), notify the Secretary of the Ministry of Health, or a person authorised by the Secretary of the Ministry of Health for the purposes of this section, of the proposed order.'

130. By cl 14 of the *Mental Health (Forensic Provisions) Regulation 2017,* where a defendant is on remand or serving a sentence of imprisonment (other than in a detention centre), a correctional officer or a police officer are "prescribed persons" for the purposes s. 33 who may take a defendant to or from a place.

131. Further, by s 55 of the MHFP Act, the Secretary of the Ministry of Health may order a person imprisoned in a correctional centre to be transferred to a mental health facility based on two certificates issued by two medical practitioners (one of whom is a psychiatrist) in the form set out in Schedule 2 to the MHFP Act. This is despite any other order made.

132. The order made by Magistrate O'Brien on 19 September 2017 directed:[112]

> "The defendant is to be taken by police, or a prescribed person as ordered by the Court, and detained *in the* mental health facility for assessment in accordance with the *Mental Health Act 2007*. If on assessment the accused is found *not* to be a mentally ill person or mentally disordered person within the meaning of the *Mental Health Act 2007*, he is to be brought by a prescribed person back before a Magistrate or an authorised officer". (emphasis added)

133. The order was directed to the Superintendent at Gissing House (Wagga Wagga Hospital inpatient unit) rather than to any declared mental health facility.

134. Registry staff at Young Local Court were advised thereafter by CSNSW that it could not comply with the order because Jonathon was a "sentenced inmate" serving a balance of parole and suggesting a s. 35 order be made in substitution.[113] The matter was raised in Court before Magistrate O'Brien who noted s. 24 of the CAS Act and declined to alter the order.

Scheduled psychiatric review on 28 September 2017

135. As at 28 September 2017, Jonathon had not undergone a further psychiatric review at Junee CC since that with Dr Jones on 30 August 2017.

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[112] Exhibit 1: Vol 3, Tab 45, Order for Assessment, p. 780.
[113] Exhibit 1: Vol 3, Tab 56, Correspondence regarding orders for assessment, p. 963.

136. On 28 September 2017, Jonathon was included on a list of inmates to be reviewed by Dr Jones. That review did not take place possibly owing to other inmates' reviews being prioritised. Tobin RN saw Jonathon in Unit B4 the following day and told him that his review would be rescheduled. Jonathon reported he had no thoughts of harming himself or others.[114]

Appearance before Magistrate Williams on 9 October 2017

137. On 9 October 2017, Jonathon appeared by AVL before Magistrate Williams at Orange Local Court. On that occasion Jonathon's legal representative referred to Dr Chew's report and submitted that his client reported still hearing voices. Another application was made under s. 33(1)(b) of the MHFP Act. Magistrate Williams granted that application.[115]

138. That same day a CSNSW representative emailed Young Local Court registry drawing its attention to the s. 33(1)(b) order and stated:

> "A defendant who is on remand or serving a sentence of imprisonment could not be transferred to a mental health facility on a s 33 order for the purpose of an assessment as this would effectively release them from CSNSW custody. In these instances, an order pursuant to s 35 MH(FP) Act…is the most appropriate order to be issued. Under s 35 order the defendant is assessed in CSNSW custody and transferred to Long Bay Hospital if found to be a mentally ill person."[116]

139. The next day, on 10 October 2017, Jonathon again appeared by AVL before Magistrate Williams at Orange Local Court. The matter was re-listed urgently due to further concerns raised by CSNSW. Magistrate Williams maintained the s. 33(1)(b) order, although his Honour remarked that it was ultimately a discretionary matter for CSNSW as to whether Jonathon would be released to a mental health facility for assessment.[117] The s. 33(1)(b) order was reissued containing a notation that the order did not override CSNSW's authority.

140. On 12 October 2017, the s. 33(1)(b) order made by Magistrate Williams the previous day was revised in chambers to an order made under s. 35 of the MHFP Act.[118]

141. Section 35 of the MHFP Act provided:

> "**35 Transfer from correctional centre or detention centre**

[114] Exhibit 1: Vol 1, Tab 10, Statement of RN Alexander Tobin dated 5 May 2019, p. 75.
[115] Exhibit 1: Vol 2, Tab 26, Orange LC Transcript, pp. 397-399.
[116] Exhibit 1: Vol 3, Tab 45, CSNSW email, pp. 756-757.
[117] Exhibit 1: Vol 2, Tab 27, Orange LC Transcript, pp. 400-412.
[118] Exhibit 2: GEO Group Investigation Report at [6.42].

(1) This section applies to a person who is awaiting committal for trial or trial for an offence or summary disposal of the person's case.

(2) If it appears to a Magistrate that it may be appropriate to transfer a person to whom this section applies from a correctional centre or detention centre to a mental health facility under section 55, the Magistrate may make an order directing:

(a) that the *defendant be examined by 2 medical practitioners, one of whom is a* psychiatrist, and

(b) that, if appropriate, the relevant certificates be furnished to the Secretary of the Ministry of Health under section 55, and

(c) that the Chief Executive Officer, Justice Health or, in the case of a juvenile, the Secretary of the Department of Justice notify the Magistrate of the action, if any, taken under section 55." (emphasis added)

Second psychiatric review by Dr Jones on 11 October 2017

142. On 11 October 2017, Jonathon was reviewed by Dr Jones for the second time.

143. Jonathon reported to Dr Jones that his prescribed Olanzapine had been ineffective and he continued to hear voices screaming and yelling at him. He also mentioned having court the previous day where mention was made of "*sending me to a + ward – left it to his gaol to do it".* Dr Jones increased Jonathon's dosage of Olanzapine to 30mg daily. The plan was for Jonathon to be reviewed again in four weeks' time.[119]

Justice Health email to Junee CC on 8 November 2017 regarding s. 35 MHFP Act Order

144. On 12 October 2017, Filomena Romano, a Forensic Mental Health Liaison Officer with Justice Health, sent an email to Ms Te Maru and Williams RN at Junee CC titled "*FW: Section 35 Court Order re: Jonathon HOGAN (MIN 545484) – detained at Junee Correctional Centre*".[120]. That email forwarded on an email sent by Justice Health earlier that day which stated:

> "Please find attached the section 35 *Mental Health (Forensic Provisions) Act 1990* Court Order for Assessment issued 12 October 2017 by the Magistrate of Young Local Court re: Jonathon HOGAN (MIN 545434) who is currently detained at Junee Correctional Centre (see below screen shot) practitioners, one of whom is a furnished to the Secretary of the Ministry of Health under s 55 of the MHFP Act 1990.

[119] Exhibit 1: Vol 1, Tab 17, Statement of Dr Matthew Jones, pp. 94.1-94.7; Vol 5, Tab 92, Justice Health Progress Note, pp.1612-13.
[120] Exhibit 8: Email correspondence enclosing s. 35 orders (12 October 2017).

> The order directs that the inmate be examined by two medical psychiatrist, and that if appropriate, the relevant certificates be Ministry of Health under section 55 of the MHFP Act 1990.
>
> The matter has been listed for mention before the Young Local Court on 5 December 2017. Please let me know the outcome of the examinations so that I can inform the Court."

145. Attached to the email was the following:

    (a) a two page policy document titled "*Custodial Mental Health Procedure: Orders under Section 35 of the Mental Health (Forensic Provisions) Act 1990 – Transfer from a Correctional or Detention Centre to a Mental Health facility'.* It included the instruction that "the Clinical Director Custodial Mental Health or the Deputy Clinical Director Custodial Mental Health will arrange for the person to be examined by two medical practitioners, one of whom must be a psychiatrist."

    (b) a sealed copy of the s. 35 order made on 12 October 2017 in respect of Jonathon.

Third psychiatric review by Dr Jones on 8 November 2017

146. On 8 November 2017, Jonathon was again seen by Dr Jones at Junee CC.

147. Dr Jones documented:[121]

    (a) "*feeling good*" (which attributed to medication);

    (b) stated his preference to be at Junee CC as it '*stabilised him*';

    (c) "*NB: ? Judge request for S 35 Assessment*"

    (d) some residual symptoms of schizophrenia but Jonathon insightful regarding illness and compliant with prescribed medication, weight at 72 kg with aim for 84 kg;

    (e) Jonathon prescribed Olanzapine 30 mg to be taken nightly (no side effects), no delusions, presented as calm, not neglecting his care, decrease in him hearing voices;

    (f) Considered suitable for employment (sentenced until Jan 2018); and

    (g) "*RW – 6/52*".

148. The noted plan was to: (1) continue the treatment and (2) review again in 6 weeks (approximately 21 December 2017).

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[121] Exhibit 1: Vol 1, Tab 17, Statement of Dr Matthew Jones, pp. 94.1-94.7.

No mental health nurse or psychiatric reviews post 8 November 2017

149. PAS records showed that Jonathon was booked and rescheduled for psychiatric review four times between 21 December 2017 and 1 February 2018. None of these appointments took place.[122]

Justice Health email to Junee CC on 8 November 2017 regarding s. 35 order

150. At 8:28am on 8 November 2017, Ms Romano sent another email to Junee CC concerning Jonathon's s. 35 assessment. Ms Romano's email was sent to Williams RN, Ms Te Maru and Tobin RN.

151. In that email, Ms Romano stated:

> "Jonathon HOGAN was issued with a section 35 Mental Health (Forensic Provisions) Act 1990 Court Order on 12 October 2017.
>
> Are you able to confirm if Mr Hogan has been assessed by two medical practitioners, once whom must be a psychiatrist and if so, what was the outcome of the assessments?
>
> I need to send notification to the Court of the outcome prior to his next hearing date which is currently listed for mention on 5 December 2017."[123]

152. The email again attached the two page policy document and s. 35 order (which had earlier been attached to Ms Romano's email on 12 October 2017).

Tobin RN email to Justice Health on 8 November 2017 at 3:05 pm

153. At 3:05 pm on 8 November 2017, Tobin RN sent an email to Trevor Perry (Justice Health) copying Williams RN. The header of the email read: "*Re: Jonathon HOGAN – s35 MHFPA 1990 Court Order – Issued: 12 October 2017*" stating:[124]

> "I am writing this email with Dr Jones by my side.
>
> He has assessed Mr Hogan today, he would not be considered a 'mentally ill person' as there are no acute risk issues and only mild current psychotic symptoms. He has not been admitted to a mental health facility and will remain under our ambulatory care."

154. Although reviewed by Dr Jones, a second medical practitioner did not review Jonathon as required by s. 35 of the MHFP Act.

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[122] Exhibit 2: GEO Group Investigation Report at [6.48].
[123] Exhibit 8: Email correspondence enclosing s. 35 orders (12 October 2017).
[124] Exhibit 4: Email correspondence between RN Alex Tobin and Trevor Perry re s. 35 orders dated 8 November 2017.

Justice Health correspondence to the Local Court on 17 November 2017

155. On 17 November 2017, correspondence was sent from the Chief Executive of Justice Health to the Magistrate at Young Local Court advising that Jonathon was assessed by a psychiatrist who formed the opinion he was displaying mild psychotic symptoms and had no acute risk issues. As a result, Jonathon was found not to be a mentally ill person under the MH Act and did not require admission to a mental health facility.[125]

Birth of youngest son on 20 November 2017

156. On 20 November 2017, [redacted] gave birth to Jonathon's youngest son.[126]

Events between December 2017 and January 2018

157. On 5 December 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court. Magistrate O'Brien noted receipt of the 17 November 2017 correspondence from the Chief Executive of Justice Health and confirmed that Jonathon did not require admission to a mental health facility. The matter was adjourned to 18 December 2017.[127]

158. On 18 December 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court. Jonathon's solicitor confirmed that he did not wish to disturb a 19 April 2017 conviction for contravening an AVO, which occurred in Jonathon's absence. The matter was adjourned to 5 February 2018.[128]

Case conferences with CO Davies

159. On 22 December 2017, a casework interview took place between Jonathon and Correctional Officer ("CO") Harlee Davies.[129] CO Davies noted that Jonathon "*rarely approaches staff*" and posed nil management concerns for staff. CO Davies further noted that Jonathon was recommended for participation in EQUIPS Foundation, EQUIPS Addiction and EQUIPS Aggression and encouraged to attend "*when a placement is made available*".[130]

160. On 13 January 2018, a further casework interview took place between Jonathon and CO Davies. The case notes indicated the same outcome as at the 22 December 2017 interview.[131]

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[125] Exhibit 1: Vol 3, Tab 58, Correspondence from Justice Health to Young LC, p. 599.
[126] Exhibit 1: Vol 1, Tab 8A, Statement of [redacted] dated 11 November 2019, p. 71.1.
[127] Exhibit 1: Vol 2, Tab 29, Young LC Transcript, p. 424.
[128] Exhibit 1: Vol 2, Tab 29, Young LC Transcript, pp. 425-427.
[129] Exhibit 1: Vol 1, Tab 19, Statement of Renee Craft dated 29 April 2019, pp. 133-187.
[130] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, p. 618.
[131] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, p. 619.

161. Regarding CO Davies' casework interviews with Jonathon, CO Davies gave evidence that:

(a) he was not aware that Jonathon was receiving mental health treatment and this was not a topic he would have questioned Jonathon about during their conversations;[132]

(b) the phone contact Jonathon had with his partner in the days preceding his death (discussed further below) is not a matter CO Davies would have had knowledge about unless Jonathon himself raised it with CO Davies; and[133]

(c) CO Davies would only have spoken to other inmates about how Jonathon was going if he noticed any change in Jonathon's behaviour.[134]

162. CO Davies' assessment of Jonathon was also informed by his general observation of him when working a shift in Jonathon's POD. On those occasions he expected he would have sighted Jonathon between 10 to 20 times each day.[135]

Court matters as at January 2018

163. On 22 January 2018, Jonathon appeared by AVL before Magistrate Day at Orange Local Court. Jonathon entered pleas of guilty to four offences. The matter was adjourned to 15 March 2018, with Jonathon ordered to appear in person on the next occasion.[136] Jonathon's criminal matters were listed for sentence on 5 February and 15 March 2018.[137]

AVL screening

164. Inmates who appear in Court via AVL from Junee C are seen by a nurse in the clinic before being returned to their cell. This is typically known as an AVL screen. These reviews typically involve a nurse asking the inmate what happened in court, what the outcome was, how they feel about the outcome and if they have any thoughts of harming themselves or others. These reviews might go no longer than a few minutes.[138]

Completion of revoked parole on 23 January 2018

165. On 23 January 2018, the balance of Jonathon's parole expired. Jonathon was relocated to Unit B2 at Junee CC (a designated remand accommodation area) and assigned to cell D04

[132] T04.12.19 at 101.22 (Davies XN).
[133] T04.12.19 at 101.47 (Davies XN).
[134] T04.12.19 at 102.3 (Davies XN).
[135] T04.12.19 at 107.29 (Davies XN).
[136] Exhibit 1: Vol 2, Tab 26, Orange LC Transcript, pp. 413-414.
[137] Exhibit 1: Vol 2, Tab 32, Young LC Transcript, pp. 425-427.
[138] T03.12.19 at 86.47 (Aylward RN XN).

as "two-out".[139] His classification changed to "C1_U UNS C1" owing to outstanding parole being completed and him returning to remand.[140]

Available mental health clinicians during January 2018

166. During January 2018, Ms Te Maru went on unplanned leave for understandable personal reasons. Williams RN acted in the role of Health Services Manager during that period.[141] During that period, Tobin RN was the staff member performing the Mental Health Nurse role on a full-time basis.

Medication compliance during January 2018

167. Medication was dispensed on an unsupervised basis to Jonathon in January 2018.

168. He attended the medication administration session in his accommodation unit each morning to be issued his daily medication. He would take that medication each night-time before bed.

169. Medication charts show that between 11 and 24 January 2018 his medication chart was not signed off by nursing staff for the dispensing of Olanzapine. That concerned 11, 15, 19, 20, 23 and 24 January 2018. The absence of a staff signature on these dates likely indicates that Jonathon did not present or receive his medication on these dates.[142]

170. The arrangements for an inmate collecting medication, for use on an unsupervised basis, as at January 2018 consisted of:

    (a) medication was dispensed from the clinic which was located separate to where most inmates were housed.[143]

    (b) the night before the night nurse would prepare a list identifying the inmates who were to be dispense medication the following day.[144]

    (c) the list is provided to correctional officers so the movement of inmates from various units to the clinic can be managed the following day.[145]

    (d) there would be a muster of inmates for a particular unit with that group of inmates being escorted or taken to the clinic to receive their medication146.

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[139] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes, p. 619; Exhibit 2: GEO Group Investigation Report at [6.60].
[140] Exhibit 1: Vol 2, Tab 41, Inmate Profile Document, p. 497.
[141] T04.12.19 at 22.35 (Te Maru XN).
[142] Exhibit 1: Vol 1, Tab 11, Statement of Jan Te Maru dated 27 May 2019, pp. 77-79.
[143] T04.12.19 at 57.12 (Te Maru XN).
[144] T04.12.19 at 6-7 (Te Maru XN).
[145] T04.12.19 at 6-7 (Te Maru XN).

(e) typically if an inmate failed to attend the muster and accompany his unit's group to the clinic for the medication round, he would likely miss getting his medication on that date.[147]

(f) at the 'window' the medication nurses had a trolley with each inmate's medication charts. Those charts were initially positioned in a horizontal lengthwise down. When an inmate collected his medication that would be noted in the file by a nurse. The file was then placed back on the trolley in a vertical lengthwise position to indicate which inmates had collected their medication.[148]

171. As at January 2018, nurses responsible for dispensing medication followed a "three-day" practice namely:[149]

(a) if an inmate missed collecting their daily medication on a particular occasion the nurses would notify those responsible for the inmate's treatment if the nurses had immediate concerns;

(b) otherwise the nurses would notify those responsible for the inmate's treatment if an inmate missed their daily medication three days in a row.

172. There is no evidence of any inquiry being made by the medication nurses of correctional officers on the missed days about why Jonathon was not attending.[150]

173. No notation was made in Jonathon's progress notes about the fact of his non-attendance being flagged as a possible concern by the medication nurses or between nurses or clinicians about the missed attendance, whether any inquiry was made of Jonathon about the reasons for his non-attendance when he attended on other occasions to collect his medication, or the fact of the missed medication was to be raised with the mental health treating team for their consideration.

Amendment of Apprehended Violence Order

174. On 29 January 2018, Jonathon appeared by AVL before Magistrate Antrum at Queanbeyan Local Court. The matter was listed for an application by [redacted] to vary an AVO in place between herself and Jonathon. Magistrate Antrum subsequently made orders deleting the non-contact condition between Jonathon and [redacted] in the AVO.[151] Thereafter, Jonathon made frequent calls to [redacted] from the prison phone.

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[146] T04.12.19 at 6-7 and 57 (Te Maru XN).
[147] T04.12.19 at 21-23 (Te Maru XN).
[148] T04.12.19 at 7 (Te Maru XN).
[149] T03.12.19 at 71 (Tobin RN XN).
[150] T04.12.19 at 37-38 (Te Maru XN).
[151] Exhibit 1: Vol 2, Tab 24, Queanbeyan LC Transcript, pp. 393-395.

Jonathon is left "one out" on 1 February 2018

175. On 1 February 2018, Jonathon was housed "one-out" following the transfer of his cellmate, [redacted], to cell D21.[152] His "normal" cell classification allowed for him to be housed one-out or with others.

176. On the same date, Jonathon called [redacted] on 12 occasions, three of which were successfully connected. During a telephone conversation at 3:06pm, Jonathon said to [redacted] that: "*Ya wanna come see me or otherwise I'm gonna neck myself*".

Phone calls between Jonathon and [redacted] between 23 January and 3 February 2018

177. Successfully connected calls exchanged between Jonathon and [redacted] between 23 January and 3 February 2018 comprised as follows:

23 January 2018	
(9:26 am)	Jonathon mentions "*…But straight up, my lawyer reckons I'm going to be doin' a long time"*.[153]
(3:17 pm)	[redacted] says she will wait for him and "…*When I find out what you get I'll just come down every weekend"*. Jonathon says "*…I don't even, they're goin' to end up moving me gaols soon"* and "*…next truck for sure, it's to Bathurst*."[154]
25 January 2018	
(2:56 pm)	[redacted] accuses Jonathon of lying. [redacted] says: "*I'm movin' on. I don't want to be with you. I'm goin' to go find somebody else who's goin' to be actually out here, and be here for me. Out here to support me and help me when I need the fuckin' help. Where are you? You're never here for me*".[155]
(3:24 pm)	[redacted] says "…*all you know what to do is get somebody knocked up, and go to gaol all the time. That's all you know what to do*."[156]
27 January 2018	
(12:51 pm)	Jonathon says he wants "*to go back down to Sydney gaols"* and he was on

[152] Exhibit 1: Vol 1, Tab 9, Statement of [redacted] dated 8 April 2019, pp. 72-74.
[153] Exhibit 1: Vol 6, Tab 99, Transcript of Inmate Telephone Calls, p.1923.
[154] *Ibid,* p.1932.
[155] *Ibid*, p.1973.
[156] *Ibid,* p.1978.

	"*BU classo again*" and due in Court in Orange.[157]
30 January 2018	
(12:05 pm)	[redacted] says she just got out of the watch-house and went straight to Care and Protection to let them know. She'd moved into a new house 11 weeks ago and police had executed a search warrant, during which they found a stolen motor bike. She assured Jonathon her fingerprints were not on it and she knew nothing about the bike (he asked why she was lying to him).[158]
(1:14 pm)	Jonathon asks "*who's fuckin' bike was it?*" and [redacted] says she will hang up the phone. [redacted] says "*I don't want to be in a relationship with somebody who doesn't trust me*…". Ends call telling him "*…I don't want anything to do with you…so seriously, don't call me*".[159]
31 January 2018	
(8:28 am)	[redacted] tells Jonathon: "*I miss you. And I hope there's a visit for Saturday*' and '*…I promise you I'll be down there this weekend'*[160]
1 February 2018	
(3:06 pm)	Jonathon asks "*Are you comin' to see me this weekend?"* and [redacted] replies: "*Yes I am…Sunday".* [redacted] says she will catch a bus to Wagga Wagga. [redacted] asks Jonathon: *"Are you excited you're goin' to see me?"* and he replies; *"Yes, I can't wait, cunt. You…come and see me I'll just neck myself".*[161]

Events of 3 February 2018

178. On 3 February 2018, Jonathon was due to be transferred to Bathurst CC the following day for an appearance at Orange Local Court on 5 February 2018.[162]

179. Correctional Supervisor ("CS") Georgina Nathan was on shift. She recalled briefly seeing Jonathon during the meal muster. She did not recall noticing anything unusual or remarkable

[157] Exhibit 1: Vol 6, Tab 99, Transcript of Inmate Telephone Calls, p. 2024.
[158] *Ibid,* pp. 2100-2111.
[159] *Ibid,* pp. 2104-2017.
[160] *Ibid*, p. 2113.
[161] *Ibid,* pp. 2134-2140.
[162] Exhibit 1: Vol 3, Tab 65, Report of CO Andrew Salmon, pp. 1057-1058; Vol 3, Tab 67, Report of CO Larissa Purnell, pp. 1060-1061.

about Jonathon that day. She was not aware of the numerous attempted calls he made to [redacted] throughout the day.[163]

180. During the day Jonathon attempted to call [redacted] on 79 occasions.[164] At 5:34pm, Jonathon made a final attempt to call [redacted] He left a message on her phone that said: "*I need you to tell me what's going on…you're really fuckin' me up*".[165]

181. Just before lockdown at 5:43 pm, Jonathon entered [redacted] cell (D20). [redacted] later advised that he had known Jonathon since 2016. Jonathon came to his cell about five to ten minutes before lock-in for a chat. Jonathon also wanted Panadol and [redacted] gave him two Panama tablets. Jonathon did not appear to be himself.[166]

182. At 5:43pm, Jonathon exited cell D20 and entered cell D04 for lockdown at 5:45 pm. His cell was secured by CO Matthew Bond and CS Georgina Nathan.[167]

183. At approximately 7:35pm, CO Scott Smith and CO Orisi Loco entered D Pod and commenced a security check of Unit B2. Shortly after entering, CO Loco attended cell D04 and attempted to conduct a check of Jonathon throughout the window of his cell. CO Loco observed Jonathon's cell door window covered up with a towel jammed between the door and the wall. CO Loco requested Jonathon to remove the towel but received no response. After knocking on the cell door, the towel eventually fell and CO Loco attempted to locate Jonathon with a torch.[168]

184. CO Loco gave evidence that initially when he looked inside the cell it was very hard to see Jonathon "*because he wasn't in the top bunk or the bottom bunk and got my torch around, shone around and I couldn't see him"*.[169]

185. At CO Loco's request, CO Smith attended Jonathon's cell. This occurred at about 7:37 pm. They both looked inside through the cell window in an attempt to locate Jonathon. They both saw Jonathon on the edge of his bed with a ligature fashioned from a bed sheet hanging around his neck.

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[163] T05.12.19 at 10 (CS Nathan XN).
[164] Exhibit 2: GEO Group Investigation Report at [6.66].
[165] Exhibit 1: Vol 6, Tab 99, Transcript of Inmate Telephone Calls, p. 2149.
[166] Exhibit 1: Vol 3, Tab 62, Transcript of Interview with [redacted], p. 1021.
[167] Exhibit 1: Vol 3, Tab 68, Report of CO Matthew Bond, pp. 1062-1063; Vol 3, Tab 70, Report of CS Georgina Nathan, pp. 1066-1067.
[168] Exhibit 1: Vol 3, Tab 74, Report of CO Orisi Loco, pp. 1074-1075; Vol 3, Tab 78, Report of CO Scott Smith, pp. 1087-1090.
[169] T05.12.19 at 15.43 (CO Loco XN).

186. CO Loco activated a Centre Emergency Response Team 1 alert ("CERT 1 code blue") via his handheld radio.[170] He also called for immediate medical assistance via radio.[171]

187. CO Loco gave evidence that correctional officers performing cell check cannot physically unlock cell doors themselves. The doors are unlocked from within the control room. Nor do the COs performing cell checks have the authority to authorise the control room to open a cell. Only the Correctional Manager of Operations ("CMO") has that authority.[172]

188. CMO Paul Errington and others made their way to the cell. On route, CMO Errington spoke with CO Loco and or CO Smith via radio.[173]

189. At about 7:39pm, CO Thomas Harrison, CO Anthony Hanley and CMO Errington entered D Pod.[174]

190. Approximately two and a half minutes passed between the CERT 1 code blue radio alert and CMO Errington's arrival at the cell.

191. At about 7:40pm, the lights in D Pod were turned on and cell D04 was opened following a direction by CMO Errington.[175]

192. At about 7:41pm, RN Petrina Meffert ("Meffert RN"), RN Amanda Sheppard ("Sheppard RN") and CO Chris Dawe entered D Pod and approached cell D04. Meffert RN proceeded to check Jonathon's vital signs and directed Correctional Officers to remove Jonathon from the cell into the Day Room Area. Meffert RN and Sheppard RN then commenced resuscitation efforts.[176]

193. CO Loco gave evidence that correctional officers continued resuscitation efforts, even when they considered they would not be able to revive Jonathon, because correctional officers are not authorised to cease resuscitation efforts. Resuscitation attempts must continue until someone with authority (such as a Medical Officer) can direct attempts to be ceased.[177]

194. At approximately 7:45pm, Meffert RN unsuccessfully attempted defibrillation of Jonathon.[178]

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[170] Exhibit 2: GEO Group Investigation Report at [5.1].
[171] T05.12.19 at 24 (CO Smith XN).
[172] T05.12.19 at 15-16 (CO Loco XN).
[173] T05.12.19 at 24 (CO Smith XN).
[174] Exhibit 2: GEO Group Investigation Report at [5.1].
[175] *Ibid*.
[176] *Ibid*.
[177] T05.12.19 at 18-19 (CO Loco XN).
[178] Exhibit 2: GEO Group Investigation Report at [5.1].

195. Meffert RN subsequently noted that "*on arrival to unit, cyanosed, no signs of life, fixed dilated pupils, no heart rate, incontinent or urine*." She also noted that Jonathon was in asystole during attempted defibrillation.[179]

196. At approximately 7:47pm, Jonathon was placed on the Striker Trolley and escorted out of D Pod to the Medical Unit.[180]

197. At approximately 7:57pm, NSW Ambulance Officers arrived at Junee CC.[181]

198. At 8:12pm, Jonathon was pronounced deceased by Dr Corbett.[182] Dr Corbett gave evidence that he was off duty but called in urgently. On arrival he assumed responsibility for control of the scene. On arrival, he saw Jonathon was asystole; meaning the defibrillator's electrocardiogram ("ECG") reading showed "a flat line" and Jonathon had a non-shockable rhythm.[183]

199. At 8:38pm, NSW Police attended Junee CC and established a crime scene.[184]

Post death investigations

200. On 16 February 2018, John Glasheen (Senior Investigator Officer, CSNSW) completed a *Serious Incident Report* regarding Jonathon's death.

201. On 28 February 2018, a post-mortem toxicology analysis showed traces of non-toxic paracetamol in Jonathon's blood.[185]

202. On 23 March 2018, Dr Hannah Elstub completed an autopsy report under the supervision of Dr Allan Cala. In Dr Elstub's opinion, Jonathon died due to neck compression. Abrasions and marks were seen on Jonathon's lateral right neck but no other significant injuries detected.[186]

203. In April 2018, Jason White completed an investigation report into Jonathon's death for the GEO Group.

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[179] Exhibit 1: Vol 4, Tab 87, Report of Meffert RN, p. 1111.
[180] Exhibit 2: GEO Group Investigation Report at [5.1].
[181] *Ibid* at [9.9], p. 888.
[182] Exhibit 1: Vol 4, Tab 88, Justice Health Progress Notes p. 1112.
[183] T05.12.19 at 30-31 (Dr Corbett XN).
[184] Exhibit 2: GEO Group Investigation Report at [13.1].
[185] Exhibit 1: Vol 1, Tab 5, Certificate of Analysis dated 28 February 2018.
[186] Exhibit 1: Vol 1, Tab 6, Autopsy Report prepared by Dr Hannah Elstub dated 23 March 2018.

A finding of "intentionally self-inflicted death"

204. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention.[187] Records indicate that Jonathon had multiple prior attempts at suicide and self-harm. We also know Jonathon was mentally ill and likely to have been experiencing auditory hallucinations to at least some degree in the lead up to his death. There are prior records indicating that he had experienced auditory hallucinations which were derogatory and commanding in nature. However, the extent or severity of his symptoms at the time he made his physical preparations is unfortunately unknown as he had not been reviewed by a mental health practitioner for some months. While I recognise that there are complex questions in relation to his capacity to make decisions at that time, I am satisfied that his death should be recorded as intentionally self-inflicted, noting the context of mental illness. His recent phone calls indicate intention and there was some planning involved in creating the ligature. Tragically, his despair may well have been transitory in nature and it is noteworthy that his death occurred shortly after he was left alone in the cell.

205. I have reviewed the conduct of the first responding correctional officers, some of whom gave evidence before me. I accept that the correctional officers acted reasonably in the circumstances they faced on 3 February 2018. No criticism is made of their response which appears to have been wholly within the guidelines in place. About two and a half minutes passed between CO Loco and CO Smith discovering Jonathon in his cell and the cell door being opened. It is understandable that Jonathon's family would be concerned at any delay in the cell being opened. However, it was explained to the court that the requirement for the CMO to attend to authorise a cell opening was a policy requirement related to safety concerns for staff and other inmates. It was not further explored at this inquest.

206. I am satisfied, given the evidence before me, that Jonathon was likely to have been dead before the cell door was opened. CPR commenced and continued until the arrival of a doctor, in accordance with protocol rather than because there was a realistic hope of revival.[188]

[187] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336).

[188] I note that records made by Meffert RN confirm that Jonathon was cynosed, fixed and dilated pupils and had no signs of life when first responding in his cell. Those observations, combined with the ECG reading indicate there was no prospect of his revival.

Part three

207. A close examination of the chronology raises a number of concerns about the overall care and treatment provided to Jonathon right from the point of his first admission to Junee CC on 2 August 2017.

The adequacy of Jonathon's mental health screening and subsequent treatment at Junee CC

The initial screening process

208. I am well satisfied on the material now before me that Jonathon was experiencing psychotic symptoms related to his schizophrenia at the time he entered custody on 2 August 2017. His experience of the disease was by then longstanding.[189] Records from his attendance at Canberra Hospital on 29 July 2017 for a mental health assessment noted his distress in the context of significant methamphetamine use. Drug use was known to trigger and exacerbate his disease. Information obtained from NSW Police indicates that he had not been taking medication for some months and he had recently been involved in extremely risky behaviour.[190] Jonathon reported auditory hallucinations when assessed on 24 and 30 August 2017 and again when he saw Dr Jones on 11 October 2017. In my view it is most likely those hallucinations were present when he first came into custody.

209. It is therefore necessary to examine the initial screening to understand why his care was not escalated from the start and why it took three weeks to commence anti-psychotic medication and longer to be seen by a psychiatrist or psychiatric registrar.

210. Jonathon's initial intake assessment took place on 2 August 2017, when he was assessed at Junee CC by Aylward RN.[191] She completed the RSA, the HPNF and also made a handwritten progress note about her assessment. Perhaps unsurprisingly, given the volume of inmates she saw and the time that has now passed, she had no memory of her specific interaction with Jonathon when she gave evidence, but was able to comment on her usual practice and the notes she had made contemporaneously.

211. She referred Jonathon to the Drug and Alcohol Nurse and the Mental Health Nurse for review.[192] She assigned the referrals a "category 2" triage classification. This indicated that Jonathon should be reviewed within 14 days.[193] She also recommended that he should be

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[189] Justice Health Medical Records confirm that Jonathon had been diagnosed with schizophrenia in August 2014 (see Exhibit 1: Vol 5, Tab 90, Medical File, p. 1138).
[190] Exhibit 1: Vol 2, Tab 34, Custody Management Record, pp. 436-444.
[191] Exhibit 1: Vol 5, Tab 93, Supplementary Medical File, pp. 1762-1771.
[192] T03.12.19 at 84.44 (Aylward RN XN).
[193] T06.12.19 at 90.26-27.

placed in a "two-out" cell for two weeks. It appears that this was a standard practice used for inmates entering custody who were withdrawing from methamphetamines.

212. A "two-out" cell placement meant another inmate would be present in Jonathon's cell during any lockdown period and could raise an alarm if he needed assistance. It was clearly an excellent idea and in my view should not have been altered without careful thought. Aylward RN told the court that while she placed him on the "two-out" for 14 days she expected that Jonathon would be reviewed by specialty nurses or the GP during that two week period when further assessment could have been undertaken.[194]

213. Much of the information recorded on the RSA appears to have been auto-populated into the form that Aylward RN completed on 2 August 2017. Factors such as cannabis abuse, depression, paranoid schizophrenia and psycho-stimulant dependence would have "automatically come up" and not have been specifically entered by her.[195] Aylward RN told the court that she would have checked the JHeHS records for any information about high risk alerts.

214. It is clear from the progress notes that Aylward RN was aware that Jonathon had previously been on medication for depression and schizophrenia, but was currently un-medicated. However there appears to have been a complete lack of curiosity about the exact nature of his current symptoms. Aylward RN made no note of asking Jonathon if he was experiencing auditory or other symptoms relating to his illness. The question apparently posed to him was: "*is there anything causing you concern*?",[196] leaving it entirely up to him to self-report the existence of such symptoms. Aylward RN agreed that had she specifically inquired about hallucinations or other symptoms, it is likely that she would have documented the answer and she did not.[197]

215. Although Aylward RN knew that Jonathon had very recently attended a hospital in Canberra in relation to mental health issues, there was no real follow up about what had actually occurred there. Aylward RN told the court that she understood Jonathon had left before treatment so "*there's going to be no medical record to obtain*."[198] Rather than pique her curiosity, this appeared to close a door to any further inquiry.

216. Perhaps more disturbing is the fact that there is no explanation for why Jonathon did not sign an authorisation to release information during this intake assessment. Aylward RN had no

[194] Exhibit 1: Vol 1, Tab 12, Statement of RN Tegan Aylward dated 28 May 2019 at [12]-[13], pp.81-82.
[195] T03.12.19 at 79 (Aylward RN XN).
[196] T03.12.19 at 82 (Aylward RN XN).
[197] T03.12.19 at 82 (Aylward RN XN).
[198] T03.12.19 at 80-81 (Aylward RN XN).

memory of an outright refusal to sign, but stated "*some people aren't forthcoming with details.*"[199] She gave some insight into the atmosphere that exists when these assessments take place, "*depending on what mood they're in too, it is reception screen. They've just been arrested. They can be agitated. They can be frustrated. Looking at my notes it was 8 o'clock at night….They might just want to be fed and get into a cell and want to get it over and done with as quickly as possible*."[200]

217. It is easy to understand that establishing rapport in those circumstances would be challenging. On reflection I think it most unlikely that Aylward RN was able to establish any meaningful rapport with Jonathon that night. When questioned about her practice in relation to obtaining information from an inmate about how they will cope in prison, she explained she asks: "*How do you think you're going to cope?*" and records their direct answer. Jonathon apparently replied "*yeah good*" and it was left at that.[201]

218. It is concerning that there is no evidence that signing the authority to release information was ever revisited with Jonathon. There is certainly no evidence indicating that requests were ever made to community or other sources. It is disturbing when one examines the wealth of material that would have been available in NSW and ACT custodial records and from community providers that Jonathon's treatment is premised almost entirely on self-report and commenced almost as though he was receiving psychiatric care for the first time.

219. The tenor of Aylward RN's evidence was that it is likely the interview was fairly quick and pretty unremarkable. She entered him on the system and trusted other appointments would take place in due course. We now know further appointments took longer than they should have, but even if they had taken place in a more timely manner, the failure to establish early rapport meant that crucial information was lost.

220. Aylward RN confirmed that there was no Aboriginal health worker available to assist in these circumstances. This is a matter to which I will return as it appears possible that had the intake nurse had the capacity to refer Jonathon to see an Aboriginal health worker or Aboriginal mental health worker the following day, in less stressed surroundings, some kind of stronger rapport could have been established and a fuller picture of Jonathon's current symptoms and psycho-social stressors could potentially have been obtained.

221. As we have seen, the following day an ISQ was completed by Kerri Lee Walker. It was recorded that he had been un-medicated "*for about a year*." Jonathon disclosed that he was

[199] T03.12.19 at 87 (Aylward RN XN).
[200] T03.12.19 at 87 (Aylward RN XN).
[201] T03.12.19 at 83 (Aylward RN XN).

not in contact with his family and that his partner [redacted] was his only support in the community.[202] The subsequent remand reception committee noted that Jonathon was an "un-medicated schizophrenic" and indicated there was an "immediate safety concern." The following day Jonathon's classification was approved as "B Medium". His "two-out" cell placement was extended to 1 September 2017 and a history of self-harm was noted.[203] He was assessed by a Drug and Alcohol nurse, noted to be in withdrawal from methamphetamine and cannabis and prescribed Phenergan.[204]

222. In my view, there was a clear and urgent need to review his psychiatric medication at this point. Even without having obtained collaborative medical notes from prior providers or adequately inquiring about his symptoms, Junee CC staff knew that he was an un-medicated schizophrenic with a history of prior self-harm. I accept Dr Eagle's opinion that "*Jonathon needed to be comprehensively assessed by a person with mental health training, whether it be psychiatrist, psychiatric registrar or an experienced mental health nurse as soon as possible so that treatment could be instituted based on his mental state and symptoms. To not do that raises huge risks in terms of deterioration in his mental state, distress, also the obvious risk of suicide. But that's actually one of the rarest risks that you can encounter. Psychosis itself can cause damage to the brain as we know. So the longer you're untreated, the more difficult it can be to treat psychosis*."[205]

223. Jonathon was left untreated for the following three weeks. During this time it is clear that he was unwell and that his presentation indicated increasing psychotic symptoms. The very fact that the Local Court made an order on 8 August 2017 that Jonathon undergo an assessment to determine if he was suffering a mental illness and whether there were reasonable grounds to believe him to be a mentally ill person within the meaning of the MH Act indicates that he is likely to have had symptoms that were obvious to his lawyer and indeed the court.

224. In my view there were deficiencies in the screening process. However, I was somewhat heartened by the evidence of Dr Spencer in relation to the potential for forthcoming change in the screening process. Dr Spencer informed the court that since Jonathon's death, Justice Health has designed a new and more sophisticated Mental Health Screening Tool. This tool is not yet in use, but subject to overcoming budgetary limitations, the court was informed that it will be converted into electronic form and rolled out to correctional facilities across NSW. I accept Dr Spencer's view that it may improve the current procedure.

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[202] Exhibit 1: Vol 3, Tab 46, Intake Screening Questionnaire, pp. 817-825.
[203] Exhibit 1: Vol 2, Tab 44, Case Management File, pp. 634-637.
[204] Exhibit 1: Vol 5, Tab 92, Medical File, pp. 1608.
[205] T06.12.19 at 61-62 (Dr Eagle XN).

225. Counsel for Matthew Hogan properly identified the lack of background information as a significant issue and urged recommendations that would prioritise the signing of medical release forms, streamline the transfer of information from other states and territories and from NSW Police.

226. I note that the solicitor appearing on behalf of the Commissioner of CSNSW advised the court that CSNSW already supply custody management records to Justice Health, and that this material formed part of the patient file in Jonathon's case.[206] It may be that Justice Health need to review how that information is stored and accessed through its improved electronic record system.

Mental Health treatment commences

227. Jonathon was first seen by the Mental Health Nurse on 24 August 2017. Jonathon told Tobin RN that he felt paranoid, thought people were talking about him and he explicitly sought medication for his symptoms. He described hearing voices. Once again he mentioned having had treatment in the ACT, but no collaborative material was sought.[207] Nevertheless it was obvious to Tobin RN that he needed medication.

228. After discussion with the GP, Dr Corbett, Jonathon was commenced on Olanzapine 10mg (twice daily) and scheduled for review with the psychiatrist, Dr Jones, the following week.

229. Tobin RN told the court that at the time this occurred it was "*a common occurrence*" that a patient such as Jonathon may be left un-medicated for three weeks.[208] He indicated that given the high volume of referrals that were placed on the mental health review list, there would sometimes be "*delays*". Ms Te Maru, the Health Services Manager, commented that three weeks before review in these circumstances was "*unfortunately a timely fashion*",[209] given the triage targets then in place.

230. Tobin RN told the court about the difficulties practitioners faced in trying to see everyone on the list and for that reason there was a necessity "*to attend to people as quickly as possible given the circumstances*."[210] This may in part explain the lack of any documentation indicating that Tobin RN had actually reviewed Jonathon's record on JHeHS or his patient file prior to this first consultation. While Tobin RN indicated that it would be best practice to record the documents he had a chance to review, he accepted that there was no

[206] Closing submissions in reply of the Commissioner of CSNSW dated 21 April 2020 at [4].
[207] Exhibit 1: Vol 5, Tab 92, Justice Health Progress Note, p. 1609.
[208] T03.12.19 at 45-46 (Tobin RN XN).
[209] T04.12.19 at 17.28 (Te Maru XN).
[210] T03.12.19 at 45-46 (Tobin RN XN).

documentation to indicate that he was aware that Jonathon had previously been diagnosed with schizophrenia in custody, his recent methamphetamine use or his prior instances of self-harm. He agreed that his knowledge that Jonathon had been on Olanzapine appears to have come from self-report rather than collaborative documentation. He agreed that he seemed to be "*getting most of the history from him*."[211]

231. In my view the delay before seeing a Mental Health Nurse, given the circumstances even as they were known at reception, was entirely unacceptable. Further it appears clear that when Jonathon saw a Mental Health Nurse three weeks after entering custody, the interaction was likely to have been rushed and suboptimal. Resource pressure meant that Tobin RN appears to have relied almost entirely on Jonathon's self-report, thereby missing the wealth of material about Jonathon which had already been collected by other health clinicians over the years.

Dr Jones's assessment and treatment

232. When Dr Jones first saw Jonathon on 30 August 2017, Jonathon had been in custody for almost one month. He confirmed that Jonathon was suffering schizophrenia. He altered Jonathon's prescription of Olanzapine to a nightly dose of 20mg and documented a review date of two weeks.

233. Once again a review of the records is somewhat troubling. It was Dr Jones' evidence that it was his practice to review patient files if they were available.[212] He expected that he would usually make a note when he had considered information from another source.[213] He conceded that his opportunity to review the patient file was in part dependent on the time available on a given day.[214]

234. Dr Jones also conceded that the majority of the information documented in the progress note he wrote during the first patient consultation came from Jonathon's self-report,[215] including that he had been on Olanzapine.[216] He agreed that he did not appear to have known about other medications named in Jonathon's records, including medication for symptoms of depression. Surprisingly, it became apparent that Dr Jones did not have access to JHeHS and would have needed to rely on a nurse to inform him of anything clinically relevant.[217]

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[211] T06.12.19 at 6.39 (Dr Jones XN).
[212] This general practice was supported in the evidence of Tobin RN (see T03.12.19 at 54.22).
[213] T06.12.19 at 11 (Dr Jones XN).
[214] T06.12.19 at 9-10 (Dr Jones XN).
[215] T06.12.19 at 11 (Dr Jones XN).
[216] T06.12.19 at 6 (Dr Jones XN).
[217] T06.12.19 at 3.25 (Dr Jones XN).

235. Dr Jones did not document a specific plan for the management of Jonathon's risk in the general prison population other than the alteration to Jonathon's medication and the scheduling of a further review. In my view there ought to have been a more explicit and documented review of Jonathon's risk. I accept that Dr Jones understood that there was some risk that Jonathon could self-harm. With the benefit of hindsight, he stated: "*He's a high risk individual by nature of a number of things, including his mental health diagnosis and his drug status, as well as his social situation, and indeed, his indigenous origin. It is a flag for awareness, given the particular natures of indigenous people being in custody; we're very sensitive to that. But may I say that he'd, he didn't stand out in that – I'm very aware of that. But that's also not an uncommon combination of risk factors*."[218] At the time of giving evidence, Dr Jones believed he would have assessed and considered the risk factors and considered that they were not of significant concern at that time.[219]

236. Once again I am concerned that Jonathon was left flying under the radar. He was by all accounts quiet, even withdrawn with those outside his immediate family.[220] He was quite unlikely to easily share his concerns with a doctor he had never met. There may have been little outward sign of his symptoms in a short consultation, particularly when the treating doctor appears to have reviewed little or no collaborative history to help prompt a response. It is telling that in amongst the challenging caseload Dr Jones faced, Jonathon "*didn't stand out*." Again I see a clear opportunity for the intervention of an Aboriginal mental health worker who may have been able to get beyond the patient's façade.

237. As we have seen, Dr Jones did not see Jonathon again until 11 October 2017; some six weeks later. Dr Jones put the delay down to the "*constant challenge*" of the review list. The list, he said was "*somewhat aspirational*" and he had to be "*mindful of resources*" when making difficult decisions about who might need to be seen urgently.[221] I have no trouble in accepting the veracity of his account of working within a very challenging environment. Nevertheless, recognition of that does not suggest the procedures were adequate or resulted in appropriate care. The problem is a systemic one rather than a professional criticism of Dr Jones.

238. The progress notes are brief but as we have seen they indicate that Jonathon reported that his dose of Olanzapine was ineffective to quell the voices he heard. Dr Jones increased Jonathon's dose and planned to review him in a month.

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[218] T06.12.19 at 13.40-46 (Dr Jones XN).
[219] T06.12.19 at 19.3-6 (Dr Jones XN).
[220] T04.12.19 at 101.6 (CO Davies XN); Exhibit 1: Vol 3, Tab 62, Transcript of Interview with [redacted] p. 1021.
[221] T06.12.19 at 20.3 (Dr Jones XN).

239. It is troubling that Dr Jones was unaware of Dr Chew's assessment and opinion at this time. Jonathon had been disrupted and required to travel a considerable distance to and from the MRRC to be assessed. Dr Chew's report was uploaded onto JHeHS by 15 September 2017. He opined that Jonathon remained "*acutely psychotic despite treatment with antipsychotics*", presented with multiple risks and met the criteria for a "mentally ill person."[222] In hindsight, Dr Jones agreed that it would have been "*helpful and valuable*" to have had Dr Chew's report.[223] However, he also stated that it would not have changed his management or decisions, including recommendations in relation to a "two-out" cell requirement.[224]

240. Counsel for Matthew Hogan urged the court to make a recommendation that Justice Health consider reviewing the current system for transporting mentally ill inmates for court ordered reports, including the use of AVL assessments. It is certainly a pertinent issue and one would expect the use of telehealth facilities will increase. However, the inquest heard limited evidence about the utility of AVL assessments with mentally ill patients. Dr Spencer gave evidence that AVL facilities are sometimes used, particularly if a patient needs to see more than one doctor.[225] The real problem that emerged in the facts of this case was that Jonathon was disrupted and moved a long distance for a report that was never even reviewed by his treating doctor.

241. The evidence before me does not clearly establish that Jonathon's mental health concerns could only have been managed in a specialised unit, rather than by a properly resourced treatment team at Junee CC at this point in his care. I note that counsel for Matthew Hogan urged me to make a recommendation that "*Justice Health and the Commissioner of Corrective Services urgently increase the number of beds available in such specialized custodial mental health facilities at Hamden or the Mental Health Screening Unit (MHSC).*"[226] In my view the issue, although extremely important, does not arise squarely on the evidence given in this inquest. Nevertheless I note that NSW coroners (including myself) have addressed this and related issues in recent times.[227] Similarly, while I accept that it is important to place inmates proximate to their families where reasonably practicable, the issues were not specifically examined during the inquest and I refrain from making a recommendation in relation to the issue.

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[222] T06.12.19 at 22-23 (Dr Jones XN); Exhibit 1: Vol 5, Tab 93, Report of Dr Gerald Chew, pp. 1778-1782.
[223] T06.12.19 at 23.4 (Dr Jones XN).
[224] T06.12.19 at 26.49 (Dr Jones XN).
[225] T03.12.29 at 35.35-36
[226] Closing submissions on behalf of Matthew Hogan dated 9 April 2020 at [24].
[227] Inquest into the death of RP and DJ (4 July 2019), Inquest into the death of Fenika Junior Fenika (Junior Fenika) (13 July 2018).

242. Dr Jones saw Jonathon for a third and final time on 8 November 2017. Dr Jones accepted that he must have been sitting with Tobin RN when Tobin RN typed the email response regarding the s. 35 order.[228] I accept that neither Tobin RN nor Dr Jones were familiar with orders made pursuant to s. 35 of the MHFP Act. Nevertheless, the email was completed without any attempt to properly document the decision making process which again probably indicates the speed with which they were called upon to work and treat mentally ill patients in custody.

243. Nevertheless, it is concerning that the procedure mandated by s. 35 of the MHFP Act was not followed. The legislature mandated that two registered practitioners separately review Jonathon. This did not occur. The information contained in Tobin RN's email was inadequate and yet it was relied upon by Justice Health when its Chief Executive advised the Local Court on 17 November 2017 that Jonathon was not assessed to be a mentally ill person under the MH Act and did not require admission to a mental health facility. That advice was in turn relied upon by the Local Court to make decisions about Jonathon's wellbeing.

244. The court heard that this process should now be operating in a manner to ensure adequate compliance with orders made under s. 35 of the MHFP Act.[229] Dr Spencer told the court that there has been a substantial increase in the number of assessments ordered pursuant to section 35 MHFPA in recent times.[230] She also outlined that in recognition of that fact Justice Health has taken steps to ensure the procedure is properly understood by relevant staff. She outlined the new and more robust oversight process.[231]

245. Her evidence was supplemented by the evidence of David Huskins, the Director of Statewide Administration of Sentences and Orders for CSNSW, who confirmed the substantial increase in the number of s. 35 orders issued by the Local Court. Mr Huskins said: "*So in - between 2016 and 2018 there were 62 section 35 orders, so that's over three years and in 2019, the 11 months to date, there's 69 section 35 orders.*"[232]

246. Records for the final appointment on 8 November 2017 are brief. As we have seen, Dr Jones records that Jonathon was somewhat improved, but there remained residual symptoms, even if the voices had decreased. Dr Jones noted that a further review would be scheduled for six weeks' time.

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[228] T06.12.2019 at 35.2 (Dr Jones XN).
[229] T03.12.19 at 35.3 (Dr Spencer XN).
[230] T03.12.19 at 31.12 (Dr Spencer XN).
[231] T03.12.19 at 34-35 (Dr Spencer XN).
[232] T05.12.19 at 77.12-14 (Huskins XN).

247. Dr Jones gave evidence that Jonathon was calm and showed some insight. He appeared committed to treatment. While Dr Jones did not recall the specific consultation, he told the court Jonathon was "*doing very well and I was happy that he was, had insight and he was engaging with us and so forth, and he was getting better. That's a win, you know*".[233]

248. Dr Jones presented as a genuine and caring professional working in an inherently difficult environment. He stood by his decision that Jonathon *could* be safely managed in the general prison population.[234] I accept that as at 8 November 2017 this may have been the case. I also understand that it was Jonathon's preference at this time to remain at Junee CC. I note that Dr Eagle did not suggest he needed to be sent to a gazetted mental health facility and considered, in circumstances where Jonathon was compliant with his treatment regime and subject to regular review, that he could reasonably be managed within the general prison population.[235] The problem, of course, was that resources did not allow regular review.

249. The stressors in Jonathon's life seemed to increase as the year went on including the birth of his child in November 2017, in a context where his other children had been removed from his care. There was also turbulence in his relationship with [redacted] and the legal proceedings associated with their domestic situation. When Dr Jones was asked about whether these kinds of psycho-social matters which could have been affecting his mental state should have been identified and managed, he disagreed. He described that kind of care as "*a solution that might be your private hospital situation*", explaining "*it's very hard to track psycho-social events in, 830 people's lives and put them together, collate them and realise their significance.*"[236] Dr Jones does not appear to have understood discussion of these kinds of issues as being part of his role, even it seems as possible triggers or factors of increased risk to Jonathon's mental health. The trouble is that nobody else had that role. The court was told that Jonathon had no access to psychological services, beyond the Mental Health Nurse (Tobin RN) and he was not eligible for other psychological programs such as EQUIPS due to the proximity of his upcoming court dates. Beyond the first intervention and prescription of Phernergan, he apparently received no drug and alcohol counselling or treatment, despite the fact that his substance issues were a longstanding problem and impacted directly on his schizophrenia.

250. It is of grave concern that after 8 November 2017, Jonathon was never again reviewed by a psychiatrist or Mental Health Nurse. Reviews were rescheduled on four occasions before his death, but on each occasion cancelled. Tobin RN explained that it was a matter of priorities;

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[233] T06.12.19 at 32.9
[234] T06.12.19 at 26.45 (Dr Jones XN).
[235] T06.12.19 at 69.29 (Dr Eagle XN).
[236] T06.12.19 at 39-40 (Dr Jones XN).

"*there was always a high volume of people who needed to access the psychiatrist and it was challenging at that particular time of year. Christmas is always a hard time for mental health as well so it was challenging to create fair and equitable access to the psychiatrist and I do recall a heavy workload around that time and a heavy number of referrals*."[237]

251. The court heard evidence from Ms Te Maru that a "*resourcing issue"* was identified following Jonathon's death and that "*extra mental health resources have been approved moving forward".*[238] Ultimately I found her evidence on this issue confusing and unsatisfactory. Ms Te Maru told the court that on 4 December 2019 approval had been granted to employ an additional three full time mental health registered nurses plus one casual mental health nurse.[239] Approval had also been given to contract a psychiatrist to provide treatment for 40 hours per fortnight, although Ms Te Maru thought it would be difficult to recruit someone for this regional position.[240] However, she explained that this increase in staffing also takes into consideration the 480 new beds planned in the next 12 to 24 months at Junee CC. A proportion of the new inmates would be high-risk inmates who presumably also require greater access to mental health services. I was left wondering if this actually constituted an improved position.

252. The court was informed that changes have also been made to reduce the numbers of referrals being made for mental health reviews. Ms Te Maru's evidence about this was also confusing. Initially she said the wait list had essentially "tripled" and that there were 300 persons on the wait list as at 4 December 2019.[241] Later in examination by counsel for GEO Group, Ms Te Maru agreed that there were in fact 39 persons on the mental health waiting list as at that date.[242]

253. Ms Te Maru agreed that GEO Group's clinical coordinator, RN Melanie Bliss ("Bliss RN"), was best placed to speak to the changes which had brought about the reduction. However, in summary the strategy she described seemed to be attempting to clear the mental health list of patients that could be properly be dealt with by a primary healthcare registered nurse.[243]

254. Bliss RN gave more detailed evidence about wait lists and the process that had recently been undertaken to reduce them. In about mid-October 2019 there were 160 people on the wait list to be reviewed by the Mental Health Nurse. By 5 December 2019 the numbers on

[237] T03.12.19 at 63-64 (Tobin RN XN).
[238] T04.12.19 at 15.14 (Te Maru XN).
[239] T04.12.19 at 18-19 (Te Maru XN).
[240] T04.12.19 at 24 and 29.35 (Te Maru XN).
[241] T04.12.19 at 18.28-40 (Te Maru XN).
[242] T04.12.19 at 55.11(Te Maru XN).
[243] T04.12.19 at 61.31-40 (Te Maru XN).

the list were down to 40 persons.[244] She explained: "*for instance, someone with no mental health, possibly a new reception who had previous mental health issue, no diagnosis, needed medication review or just wanted to have a chat. For example, that person, depending on what history we could find on them at the time, it would be more appropriate for a GP referral.*"[245] She continued, suggesting others may be more appropriately referred to a primary nurse, psychology or the chaplaincy service.

255. Later when discussing triage categorisation, Bliss RN gave somewhat confusing evidence about how quickly someone with Jonathon's background would be seen now that changes had been made to the wait list process. She stated that she was confident that he would be seen within one month.[246]

256. At the conclusion of the evidence on changes to the waiting list, I remained concerned that unless the under resourcing of mental health services at Junee CC[247] was faced squarely, no administrative solution involving shifting inmates to other lists would solve the problem or ensure greater safety for inmates, particularly in circumstances where the prison population at Junee CC is about to expand substantially.

257. There is little doubt that the mental health care offered to Jonathon was poorly coordinated and planned. The evidence indicated that medical staff at Junee CC were seriously under resourced. As a result it appears likely that those with more dramatic presentations would be prioritised on overcrowded waiting lists. The care offered was largely reactive and treatment plans or schedules for upcoming appointments were "*aspirational*" in nature.[248]

258. I accept Dr Eagle's view that Jonathon needed closer monitoring. She stated "*the auditory hallucinations were particularly significant…in his presentation…in the individual context…Having regard to all of the other factors as well that made him particularly vulnerable, he would need to be reviewed in my view, at least by some sort of mental health person every couple of two to four weeks in order to ensure that he was…remaining stable in that environment*".[249] She also stated that when initiating medication to someone identified as "*acutely psychotic*", "*I would have thought you needed to see them every week to two weeks.*"[250]

[244] T06.12.19 at 87.10 (Bliss RN XN).
[245] T06.12.19 at 88.17-26 (Bliss RN XN).
[246] T06.12.19 at 89.40 (Bliss RN XN).
[247] T04.12.19 at 15.17-22 (Te Maru XN).
[248] T06.12.19 at 20.3 (Dr Jones XN).
[249] T06.12.19 at 65.7-13 (Dr Eagle XN).
[250] T06.12.19 at 63.14-15 (Dr Eagle XN).

259. Counsel for GEO Group made the submission that where Dr Eagle and Dr Jones have differing opinions on the treatment provided to Jonathon, Dr Jones should be preferred, given he had the opportunity to review the patient and Dr Eagle had "*limited clinical experience in a custodial setting*". I do not accept that submission. As was correctly identified by counsel assisting, Dr Eagle was retained by the court as an independent expert who was not directly involved in the care and treatment of Jonathon. She has extensive experience in the provision of psychiatric treatment in both community and correctional centres, including at the Forensic Hospital at Long Bay Correctional Centre. At no stage during the inquest was it put before Dr Eagle by counsel for GEO Group that she was not suitably qualified or experienced to express the opinions that she did in respect of Jonathon's care and treatment. Further, Dr Jones did not dispute the reasonableness of the views express by Dr Eagle in her report.[251]

260. Dr Jones gave evidence that if he had any concerns about Jonathon's risk factors he would have communicated that through the HPNF form which is a direction to operational staff to observe Jonathon.[252] This may well be the case and this is where part of the problem lies. Dr Jones did not see or review Jonathon in the last months of his life. He would not have known whether new risks had arisen and a new HPNF form was called for. He can add little to our knowledge of Jonathon's mental state after early November 2017. Dr Eagle was asked to review all the available records right up until Jonathon's death. I accept her opinion that Jonathon required more intensive monitoring and psychiatric care.

261. I remain concerned that at a number of points throughout Jonathon's time in custody there were issues in relation to the management of clinical records which impacted negatively on his care. Some information was held in hard copy files which travelled across the state. Some was placed on JHeHS, which as we have seen was not always checked by Jonathon's treating clinicians. It is difficult to judge what impact the new electronic records system will have. Dr Spencer told the court that the process had commenced as the inquest was in process.[253] One hopes it has the desired effect of improving the efficiency of Justice Health's information flow.

Medication

262. Of some concern is that Jonathon missed medication on six separate dates between 11 and 24 January 2018. The court explored whether this in itself should have triggered a review of his wellbeing. Nothing was documented in his progress notes to suggest that further inquiries

[251] Closing submissions in reply of counsel assisting dated 23 April 2020 at [12].
[252] T06.12.19 at 50.37-51
[253] T02.12.19 at 86.10 (Spencer XN).

were made with Jonathon or any other person about these gaps. There is nothing to suggest it was brought to the attention of his treating doctor or the mental health nurse.

263. Ms Te Maru and others spoke of a practice in place at Junee CC whereby a medication review was triggered by missing medication on three or more days.[254] Dr Jones considered the triggering of a review after missing three consecutive days as reasonable in a custodial setting.[255]

264. Dr Eagle was asked to comment on the significance and possible impact on Jonathon of these missed medications. In her view it was an "*extremely important*" factor. She said: "*I think the fact that he had been reasonably compliant with his medication for a number of weeks and had actually identified that it was helping with distressing symptoms of his illness, and then had started not attending quite regularly, so up to six times…so not attending to collect his medications, that needed to be assessed because it could've been due to a variety of reasons".*[256] She also offered the opinion that given he required a high dose of Olanzapine to stabilise his illness, the missed doses over a short period of time would likely have started to cause a deterioration of his mental health.[257]

265. The court did not receive detailed evidence about Justice Health medication policies which are apparently voluminous. Instead it focussed on how this change in Jonathon's compliance may have been relevant to his treatment.

266. The court was informed that since Jonathon's death, changes have been made which may mean that missed doses may be more easily detected and therefore reviewed.

267. Since his death, Junee CC has trialled satellite medication dispensing stations in each unit. Rather than requiring the inmate to attend the clinic to collect their medication, the medication nurses dispense in the unit. In Ms Te Maru's view, there is less prospect of an inmate missing his medication because he slept in or missed the medication muster.[258]

268. Counsel for Matthew Hogan submitted that a review should specifically investigate the "three day rule" and the medical appropriateness of such a rule.[259] I agree that some review of the

[254] T04.12.19 at 9.32 (Te Maru XN).
[255] T06.12.19 at 44.9-33 (Dr Jones XN).
[256] T06.12.19 at 69-70 (Dr Eagle XN).
[257] T06.12.19 at 70 (Dr Eagle XN).
[258] T04.12.19 at 12-13 and 57-58 (Te Maru XN).
[259] Closing submissions on behalf of Matthew Hogan dated 9 April 2020 at [13].

system is required, even after hearing about the changes already made, but I am content that the more general approach urged by counsel assisting is sufficient.[260]

The adequacy of specific support offered to Indigenous inmates

269. As discussed above, Junee CC had the benefit of regular visits from the south west region RAPO, who is employed by CSNSW. Mr McAdam gave evidence that his area included 17 correctional centres from Cooma to Broken Hill. When at Junee CC he met with the AIDC, supported various art projects, assisted inmates at the time of their release, among many other duties. Mr McAdam impressed as a highly energetic and committed man doing his level best to undertake a role that could have been shared by a number of individuals. It is clearly beyond the scope of this inquest, but I have little doubt Mr McAdam could use extra resources over such a huge area.

270. Mr McAdam gave evidence that although he did not recall meeting Jonathon, he became involved in organising a memorial service for inmates affected by Jonathon's death. I have no doubt that it was bittersweet evidence for Jonathon's family. The fact that Jonathon was honoured and shown respect would have been balanced with sadness that they were not contacted to attend.

271. The court was somewhat heartened to learn of new procedures in place aimed at better family liaison after a death in custody. The solicitor acting for the Commissioner of CSNSW outlined that since February 2018, the Aboriginal Strategy and Policy Unit at CSNSW had developed specific procedures regarding Aboriginal deaths in custody. This procedure was tendered at the conclusion of the inquest.[261] It is apparent that Junee CC did not reach out to Jonathon's family after his death. I have no doubt this compounded their grief. I urge Junee CC to ensure these new policies improve care provided to families.

272. The court also heard evidence from Mr Gerome Brodin, the cultural advisor employed by GEO Group and based at Junee CC. His role involved organising a diverse range of cultural activities which included NAIDOC week and Chinese New Year among other occasions. While Mr Brodin had intermittent contact with the AIDC, his role was not one specifically aimed at one-on-one interaction with Aboriginal inmates.

273. I have grappled with trying to understand what interventions, if any, could possibly have made a difference to Jonathon. He needed to be seen and heard by someone who was able to get past his quiet façade and understand the nature of his significant symptoms and

[260] Closing submissions of counsel assisting dated 2 March 2020 at [111].
[261] Exhibit 18: Aboriginal Strategy and Policy Unit – Aboriginal Death in Custody.

concerns. He needed an advocate within an under-resourced system. In my view the evidence demonstrates a clear need for Aboriginal Mental Health Workers at Junee CC. The evidence disclosed that well intentioned non-indigenous doctors and nurses had been unable to establish any significant or consistent rapport with Jonathon or even acquire permission to seek collaborative information from community or family sources. There was nobody that had the time or that Jonathon had sufficient trust in to discuss his significant relationship and other mental health difficulties. There is no record of anyone talking with Jonathon about his family or the possibility of reconciliation and support from them. We know Jonathon faced enormously stressful situations whilst in custody, including the birth of his son against a background of prior child removals, and the tumult and breakdown in his relationship with [redacted] We know he was unlikely to speak to officers about these issues. It is just possible that a skilled Aboriginal Mental Health worker could have made a positive intervention and developed a more positive therapeutic alliance. It is a strategy that deserves consideration.

274. Counsel assisting urged the court to consider a recommendation for creating a full time Aboriginal Health Worker position at Junee CC. I note that Ms Woods, who gave evidence as the Acting General Manager of Junee CC, indicated that GEO Group was "*absolutely*"[262] open to the possibility of employing a dedicated Aboriginal health worker at Junee CC. Ms Wood confirmed that CSNSW had given approval for Junee CC to commence recruitment of an Aboriginal Liaison Worker, although this appeared to coincide with the expected expansion of the prison population. Ms Wood gave evidence that Junee CC intended to increase its proportion of Aboriginal and Torres Strait Islander employees to above 6% of the staff population; which sat at 2.7% during the inquest. Ms Wood said: "*We are constantly looking for ways to develop those networks and those relationships and the rapport with the local community. It will never cease. The recommendation probably will never be closed, because it should be continued to be worked on*."[263]

275. In my view, the number of indigenous inmates at Junee CC would suggest that more than one Aboriginal Health Worker would be required. One isolated staff member doing that role would certainly be overwhelmed. Consideration should be given to employing a number of Aboriginal health workers, particularly with the planned expansion at Junee CC. At least one of those positions should be dedicated to mental health care and treatment.

The adequacy of other methods to reduce risk at Junee CC

276. Custodial staff are guided by medical staff in relation to cell placement. For almost all of his time in custody Jonathon was placed with another inmate even when his classification meant

[262] T04.12.19 at 84.6 (Wood XN).
[263] T04.12.19 at 82-83 (Wood XN).

that he could have been placed alone. It is significant that his death takes place soon after being left in his cell alone.[264]

277. The inquest did not examine detailed evidence in relation to the cell placement issue. At the conclusion of proceedings, Counsel for GEO Group submitted that there was no evidence that Jonathon's cell placement was inappropriate and/or in breach of any GEO Group or CSNSW policy. I accept that there was no evidence that Jonathon ever came to the attention of the High Risk Assessment Team ("HRAT") and/or Critical Incident Team ("CIT"). The question is not whether there was breach of a policy, but whether staff really had sufficient information to inform their decisions in this regard.

278. The matter is well addressed in the counsel assisting's reply submissions.[265] I accept that it is the *absence* of evidence specifically in the period from 8 November 2017 to 3 February 2018 that is the critical issue. During this period there were no reviews from a psychiatrist or mental health nurse, other than the very limited AVL screens after court. Jonathon's case manager, CO Davies, was not even aware Jonathon was receiving mental health treatment and did not question him on that topic. In my view Junee CC officers had limited information on which to properly base a placement decision during this period.

279. Correctional staff currently take advice from medical staff about whether an inmate should be placed "two-out". It is generally accepted that inmates are less likely to hang themselves when housed with another prisoner. Not only is there the possibility that the relationship between the inmates is in itself protective, there is also the possibility that early discovery of any self-harm will avert complete disaster. In my view there were unfortunate gaps in the information medical staff were able to collect. It may be that this is an area where an Aboriginal mental health worker's input would have been of great assistance. Dr Eagle described Jonathon as a "*highly isolated and vulnerable inmate*"[266] who could not be relied upon to articulate what was happening for him.

280. The court heard about various mechanisms used by Junee CC to manage risk. CO Davies was assigned as case officer for Jonathon between October 2017 and January 2018. He spoke briefly to Jonathon on 21 October 2017, 11 November 2017, 22 December 2017 and 13 January 2018 about his progress.[267] CO Davies considered Jonathon to be "a quiet inmate" who spent the majority of his time in his cell or working out, he rarely approached staff.

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[264] It should be noted that despite the expiry of the formal "two out" cell placement, Jonathon remained in a "two out" placement until 1 February 2018 when his cellmate was transferred.
[265] Closing submissions in reply of counsel assisting dated 23 April 2020 at [5]-[7].
[266] T06.12.19 at 85.10 (Dr Eagle XN).
[267] Exhibit 1: Vol 2, Tab 43, OIMS Case Notes.

281. Other checks such as those that occur after a court appearance were also superficial and in the circumstances unlikely to obtain useful information from an inmate such as Jonathon. Aylward RN described the process as typically involving asking the inmate a few questions about the court outcome. She said: "*We then ask how they're feeling about that. Are they upset? Do they have any thought of hurting themselves or anyone else*?" It might take a few minutes.[268] The process may assist some inmates, but it appears unlikely to have triggered a request for help from Jonathon.

282. One issue that received consideration was the number of calls Jonathon made in the lead up to his death and whether closer monitoring of calls offers an opportunity to reduce risk. As we have seen Jonathon's relationship with [redacted] was in crisis in the period leading up to his death. At one point he was expecting a visit and as that possibility receded he appeared to become increasingly distressed. In the days preceding his death Jonathon spoke to or left messages for [redacted] on about 13 occasions, with many more calls attempted.[269] The calls contain declarations of love but are also at times aggressive, frustrated and full of conflict.

283. As we have seen, on the day of his death Jonathon made numerous attempted calls to [redacted]. He was upset at her not answering his calls and seemed unsure what was going on. His last call was made at 5.34pm about an hour and a half before cell lockdown.[270] Recordings of the call show that he was loud and there was a level of stress in his voice.[271]

284. Telephone calls are monitored in all correctional facilities for operational reasons. The inquest touched upon whether this process could be used to somehow provide a safety net in circumstances such as Jonathon's. In other words could the number of calls alert someone to the possibility that an inmate was in extreme distress.

285. The court was informed that CSNSW is responsible for the Offender Telephone System ("OTS") in all NSW correctional centres, including privately operated facilities such as Junee CC. The system and its functionality is operated and controlled by a third party contractor. Representatives for the Commissioner of CSNSW told the court that currently there is no function that triggers an automatic alert once a certain threshold number of calls is reached. Any change to the system or functionality would require variation to the contractual agreement between CSNSW and the third party contractor.[272]

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[268] T03.12.19 at 86.39 (Aylward RN XN).
[269] Attempted calls numbered 78, including calls that were abandoned prior to going to message bank.
[270] Exhibit 1: Vol 6, Tab 99, Transcript of Inmate Telephone Calls, p. 2149.
[271] T02.12.19 at 24.50 (Detective Sergeant Tesoriero XN).
[272] Closing submissions on behalf of the Commissioner of CSNSW dated 8 April 2020 at [8].

286. CSNSW did not support a recommendation to examine whether the existing telephone system could be adapted to include an alert system when an inmate makes a significant number of calls to a particular number in a short period. It was suggested that this could involve a serious cost implication.[273] More importantly, it was suggested that it may have unintended consequences and even act as a disincentive for inmates to use the system and thereby isolate themselves from support networks in the community. An alert system may also identify inmates frequently calling a partner, where no issues exist and not identify inmates who make few but more problematic calls. It was suggested that more regularly running an existing function "Frequently Used Summary Report" for at-risk inmates could assist in identifying problematic use without changes to the contract in place.[274]

287. In my view, while complex, the issue deserves further consideration.

The adequacy of cell architecture at Junee CC

288. Junee CC was built in 1993 by the GEO Group, who was responsible for the design, construction and operation of the Centre.[275] Available data indicates that there have been four deaths at Junee from either suspected or confirmed suicide; the last of which was Jonathon in February 2018.

289. The court heard from Terry Murrell, General Manager, State Wide Services, CSNSW that Junee CC had experienced fewer suicides than some of the larger centres, both private and public.

290. Counsel for CSNSW submitted that CSNSW is committed to ongoing review and consideration for the removal of hanging points across NSW. There was evidence that CSNSW has undergone a program of audits which has resulted in some retrofitting in certain facilities.[276] In determining which facilities should be subject to retrofitting, CSNSW submitted that it must "*take into account several considerations such as need, risk, cost and the existing building structure*."[277]

291. CSNSW submitted that "*all deaths in custody are tragic and every effort should be made so that they do not occur. Given Junee CC experiences very few deaths in custody when compared to other centres the focus is instead on risk assessment and appropriate cell*

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[273] *Ibid* at [22].
[274] Closing submissions on behalf of the Commissioner of CSNSW dated 8 April 2020 at [25].
[275] Exhibit 1: Vol 1, Tab 19B, Statement of Terrence Murrell dated 11 October 2019, pp. 187.1-187.3.
[276] T03.12.19 at 98.35 (Murrell XN).
[277] Closing submissions on behalf of the Commissioner of CSNSW dated 8 April 2020 at [11].

placement as opposed to costly alterations to existing structures."[278] Further, it was submitted that the newly built 480 bed area at Junee CC will give officers greater scope to be able to place inmates in a cell with a design "*appropriate to their risk and needs*" presumably because there will be more safe options.

292. As we have seen, Jonathon managed to secure a ligature around a frame positioned on the side of the top bunk. These frames were installed within the minimum security section in 2014 when an inmate rolled out of bed and injured himself.[279] This installation was done in consultation with CSNSW. GEO Group indicated that it had more recently consulted with CSNSW and received funding from CSNSW to install different style beds in particular areas.[280]

293. Ms Wood gave evidence that the cell Jonathon died in remains as it was.[281] However, she said there was currently a prototype being developed that would remove that kind of ligature point. She explained that the cells currently under construction at Junee CC would have the new style bed fitted and that it was a general intention to remove old and redundant bed stock and retrofit a safer option. No time frame could be given.

294. Both CSNSW and Junee CC appeared to accept that while prisoners are placed in cells such as the one Jonathon died in, risk exists. The primary risk mitigation strategy involves being able to identify which inmates should be placed in safer areas or in "two-out" placements. As we have seen this relies on proper resourcing of medical assessment and treatment so that reliable information can be provided to custodial staff.

295. Ligature points in prison cells have been an issue for decades. I accept that cell placement strategies have a place in risk mitigation, however we also need to do more about retrofitting cell furniture. Again, the issue is one of proper resourcing. Submissions made by CSNSW make this very clear. Implementing change within the area where Jonathon died "*would be cost prohibitive when weighed against other centres and units which present higher risk and need.*"[282] Thirty years on from the RCIADC, this is entirely unacceptable.

Conclusions regarding medical care and custodial care

296. I am substantially guided by the matters set out in counsel assisting's submissions to summarise the inadequacies in the care provided to Jonathon during his final six months in

[278] *Ibid* at [19].
[279] Exhibit 1: Vol 3, Tab 55, Occupational Injury Record at [8.1.14], p. 923.
[280] T03.12.19 at 98-100.
[281] T04.12.19 at 88.35 (Wood XN).
[282] Closing submissions on behalf of the Commissioner of CSNSW dated 8 April 2020 at [21].

custody.[283] Specifically, there appears to have been a lack of curiosity and inadequate investigation of collaborative sources of information. This manifested itself in a number of ways including:

(a) Treatment was principally based on Jonathon's self-reports without consideration of past records or other sources of collaborative information.

(b) No attempt was made to source information from the collaborative sources about Jonathon's prior mental health and treatment in the community and ACT custody.

(c) Dr Chew's report, which was uploaded to JHeHS by 15 September 2017, was never considered by clinicians at Junee CC.

(d) The reasons underlying Jonathon missing medication in January 2018 were never explored with him.

(e) There was no real opportunity for Jonathon to discuss some of the complex psycho-social issues he faced, such as estrangement from family and conflict in his relationship with [redacted]. While custodial staff, including his case manager, checked on Jonathon at regular intervals, the contact was brief and largely superficial.

297. Dr Chew's report recommended intensive treatment. Those responsible for Jonathon's day to day care ought to have considered this recommendation in planning the frequency of Jonathon's mental health reviews.

298. The length of time Jonathon was left untreated following his admission into custody at Junee CC is of significant concern. A person known to suffer schizophrenia should not wait three weeks for review. This is below the standard one would expect in the public health system and is unacceptable.

299. The frequency of mental health reviews, consisting of three reviews by a psychiatrist and one by a mental health nurse during Jonathon's six months in custody was inadequate. Jonathon required an individualised treatment plan which included regular monitoring and treatment reviews.

300. Placing Jonathon alone in a cell with a hanging point involved substantial risk. Cell placement decisions were based largely on medical advice. The degree of risk at the time he died was not known by those involved in his medical care, because there had been no psychiatric review since November 2017.

[283] Closing submissions of counsel assisting dated 2 March 2020 at [87]-[92].

301. I am satisfied that greater frequency of reviews, closer monitoring, and increased curiosity and attention to rapport building is likely to have made a difference to Jonathon's mental and emotional wellbeing as at 3 February 2018. Whether it would have been enough to save him from the despair he felt on 3 February 2018 I cannot say. The lack of medical observation of him during the months preceding his death preclude me from knowing the extent of his psychotic symptoms at that time.

302. I am confident that input and involvement from an Aboriginal Mental Health Worker could have been an important component of improved care which could also have impacted on Jonathon's mental state. The provision of culturally appropriate treatment and cell placement must be pursued. In my view, Jonathon was not seen in a crowded system. As Dr Jones reported: "*he didn't stand out*."[284] In my view his care was compromised and not sufficiently geared to his individual needs.

Outstanding concerns and the need for recommendations

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

304. The evidence arising during this inquest demonstrated a strong need to consider specific recommendations particularly in relation to Jonathon's mental health treatment and custodial care. The following recommendations I make arise directly out of the evidence before me. Beyond these recommendations I must again draw attention to the shocking and ongoing over-representation of Aboriginal citizens in custody. The RCIADIC identified that this inequality is born from racism and dispossession. While I accept redressing such matters goes well beyond my legal task, I am nevertheless compelled to record the true contextual background of Jonathon's death.

Findings

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

Identity

The person who died was Jonathon Hogan.

[284] T06.12.19 at 13.44 (Dr Jones XN).

Date of death

He died on 3 February 2018.

Place of death

He died at Junee Correctional Centre, Junee NSW 2663.

Cause of death

He died of neck compression as a result of hanging.

Manner of death

Jonathon was mentally ill at the time of his death. He was alone in his cell. I find that his death was intentionally self-inflicted in circumstances of being held in custody with inadequate mental health care in the preceding months.

Recommendations pursuant to section 82 *Coroners Act 2009*

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

To the Chief Executive Officer, GEO Group Australia Pty Ltd

The GEO Group Australia Pty Ltd ("GEO Group"):

1. Review the Junee CC's practice and procedures at the intake stage to ensure that inmates with known diagnoses for serious mental illnesses (e.g. schizophrenia) are reviewed by a suitably qualified mental health clinician in a timely manner for the purposes of:
    (a) assessing the inmate's condition.
    (b) consulting with other clinicians (if necessary) and to make recommendations about treatment (including whether the inmate requires antipsychotic medication)
    (c) documenting what the inmate's risks are and how those risks are to be managed assuming the inmate is placed within the general population (including the possibility of "two-out" cell placements).

2. Examine the current ratio of mental health treating staff, to inmates requiring mental health reviews and treatment, and whether the staffing ratios and resources are sufficient to ensure:
    (a) inmates who are suffering serious mental illnesses are reviewed by a suitably qualified mental health clinician in a timely manner after entering the Junee CC
    (b) inmates who are suffering serious mental illnesses thereafter are reviewed by a psychiatrist or by another suitability qualified mental health clinician at reasonable

intervals having regard to the severity of their illness, circumstances and the potential changeability of their condition.

(c) mental health clinicians carrying out patient reviews are afforded a reasonable opportunity to review an inmate's patient file and other collaborative sources.

3. In consultation with Justice Health, review the Junee CC's practice and procedures as regards the provision of antipsychotic medication to ensure, in the event an inmate misses taking their daily antipsychotic medication, the mental health treating team is notified of this fact and the inmate reviewed about this issue in a timely manner (specifically taking into account the opinion expressed by Dr Kerri Eagle in these proceedings about the impact of an inmate missing Olanzapine medication).

4. Consider creating at least three full-time equivalent Aboriginal Health Worker positions based at the Junee CC, at least one of whom has responsibility for the provision of mental health care and treatment to Aboriginal inmates.

To the Chief Executive Officer, GEO Group Australia Pty Ltd and the Commissioner of Corrective Services NSW

5. GEO Group in consultation with Corrective Services NSW ("CSNSW") urgently examines replacing or altering the bed frames of the kind used within the B2 Unit at Junee CC on 3 February 2018 to remove possible hanging points.

To the Commissioner of Corrective Services NSW

6. CSNSW, in consultation with other stakeholders, examine the utility of adapting the telephone system available for inmate use to include an alert system when inmates make a significant number of calls to a particular number in a short period.

Conclusion

307. Finally, I offer my sincere thanks to counsel assisting, Christopher McGorey and his instructing solicitor James Loosley for their hard work and enormous commitment in the preparation and conduct of this inquest. I thank the parties for their comprehensive submissions.

308. Once again, I offer my sincere condolences to Jonathon's friends and family. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing. I am so sorry that Jonathon experienced such despair in circumstances which were unsafe for him. In my view, the state failed to provide Jonathon with adequate care at a time when he was in great need.

309. I greatly respect Matthew Hogan's decision to participate in these difficult proceedings to achieve change and I thank him again for his courage and grace in such circumstances.

310. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
6 May 2020
NSW State Coroner's Court, Lidcombe