CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Matthew Richard Lothian
Hearing dates:	30 September – 4 October 2024
Date of Findings:	24 September 2025
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – section 23 mandatory inquest – death in custody – inmate took firearm from escorting officer – self-inflicted death of inmate by gunshot – findings as to manner and cause of death – consideration of *Crimes (Administration of Sentences) Regulation 2014* – serviceability of firearm holsters issued to Corrective Services officers
File number:	2021/4815
Representation:	**Counsel Assisting:** R Ranken SC with Grainne Marsden, instructed by L Sampson, NSW Crown Solicitor's Office **Counsel for Corrective Services NSW**: T Stevens, instructed by C Dunn, NSW Department of Communities & Justice Legal **Counsel for Michael Greer:** J Nottle, instructed by P James, Operational Legal Australia **Counsel for Glenda Harvey and Jose Noronha:** S Russell, instructed by M Jaloussis, McNally Jones Staff Layers **Counsel for the Justice Health & Forensic Medicine Network:** J Harris, instructed by K Hinchcliffe, Makinson d'Apice Lawyers
Protective orders	Final non-publication orders have been made prohibiting publication of various CSNSW policies, procedures and training materials. A copy of the orders may be obtained on application to the Coroner's Court Registry.

Findings:	**Identity:** The person who died was Mathew Richard Lothian (Mathew). **Date of death:** Mathew died on 6 January 2021. **Place of death:** Mathew died in Wollongong, New South Wales. **Cause of death:** Mathew died from a gunshot wound to the head and neck. **Manner of death:** Mathew died as a result of a self-inflicted gunshot wound that he inflicted with the intention to end his own life, while being transported on medical escort.
Recommendations:	To the Justice Health and Forensic Medicine Network and the Commissioner of Corrective Services NSW, I recommend: 1. Justice Health NSW and Corrective Services NSW consider the benefits of therapeutic psychological services being provided by Justice Health NSW, including how such services would be funded. To the NSW Attorney General and to the NSW Minister for Corrections, I recommend: 1. That there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, cl 299 of the Crimes (Administration of Sentences) Regulation 2014, having regard to the findings in the inquest into the death of Mathew Richard Lothian. To the Commissioner of Corrective Services NSW, I recommend: 1. That Corrective Services NSW urgently develop serviceability criteria for the assessment of

	whether holsters and associated equipment related to the retention of firearms are in a proper operational condition and develop training for correctional officers in the assessment of the condition of that equipment according to that serviceability criteria. 2. That an urgent audit be undertaken of all armouries to identify and remove any holsters and associated equipment related to the retention of firearms that may not be in proper operational condition.

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

Introduction

1. This is an inquest into the death of Mathew Richard Lothian. Mr Lothian died on 6 January 2021 outside 355 Gladstone Avenue, Wollongong from a self-inflicted gunshot wound to the neck and head.
2. At the time of his death, Mr Lothian was 37 years old and was incarcerated at the South Coast Correctional Centre (**SCCC**).

Jurisdiction, role of the coroner and scope of the inquest

3. As Mr Lothian was temporality absent from a correctional centre at the time of his death, jurisdiction to hold this inquest arose under s 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009* (NSW) (**the Act**), and the inquest was mandatory.
4. It is not my role to attribute blame to any person or persons for Mr Lothian's death or to make findings of guilt. Rather, my role, pursuant to s 81 of the Act, is to hand down at the conclusion of the inquest findings as to the identity of the deceased, together with the date and place of death; and, if concluded, findings as to the manner and cause of the death.
5. Additionally, I have the power to made recommendations if there are revealed to be any matters that might enliven the provisions of s 82 of the Act, which deal with possible recommendations as to public health and safety.

Background facts

6. Much of the factual background set out below was helpfully outlined in the opening address of Senior Counsel Assisting. Unless otherwise indicated, the evidence underlying the factual background which follows is uncontentious and was not the subject of dispute between the interested parties to the inquest.
7. As will become apparent, issues as to the identity, date and place of Mr Lothian's death are uncontroversial and the evidence is sufficient for me to find that Mr Lothian died at around 12:30pm on 6 January 2021 outside 355 Gladstone Avenue, Wollongong in New South Wales. As to cause of death, that too is uncontroversial: Mr Lothian died from a self-inflicted gunshot wound to the neck and head. Much of the evidence examined at the inquest focussed on the circumstances leading up to Mr Lothian's death.

Mr Lothian's early life

8. Mr Lothian was born Mathew Tyerman on 5 October 1983 at Mona Vale District Hospital.[1] He was the first of two sons born to his mother, Deborah Tyerman.[2]
9. In 1991, Mr Lothian's mother married Gary Lothian. While Gary Lothian did not formally adopt Mr Lothian and his brother, both children later changed their surnames from Tyerman to Lothian.[3]
10. Mathew attended Summer Hill Public School and Canterbury Boys High School. According to his mother, Mathew 'started hanging around a bad bunch of kids' in around in year 5 and started smoking and graffitiing.[4] He 'didn't really like school', attended sporadically and 'ended up dropping out before he completed year 10'.[5] After leaving school, he engaged in casual labouring work for a period.[6]

Offending and drug addiction

11. According to his mother, Mr Lothian first went into custody when he was around 13 or 14 years old.[7] This is consistent with his juvenile criminal history. Mr Lothian was first charged with a criminal offence when he was 13 years old.[8] His offending escalated throughout his adolescence. In 1999, when he was 15 years old, he received his first custodial sentence. By the time he was 16 to 17 years old, he was consistently receiving custodial sentences for his offending.[9]
12. This pattern of offending continued after Mr Lothian turned 18. Between the ages of 18 and 37, Mr Lothian was regularly charged with offences that saw him spend periods in custody and subject to supervision from Community Corrections. He was primarily charged with property offences for which he was sentenced in the Local Court.[10]
13. According to his mother, Mr Lothian 'had an addiction with drugs' and would use 'any drug that he could get' including heroin and the drug 'ice'.[11] She has reported that Mr Lothian mainly used 'ice' because it was inexpensive.[12] Mr Lothian's history of drug use is reflected in his criminal history.

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[1] V1/8A – Ex A - NSW Birth Certificate of Mathew Tyerman.
[2] V1/8A – Statement of Deborah Lothian dated 26 October 2021 (**D Lothian 26.10.2021**) at [3].
[3] V1/8A – D Lothian 26.10.2021 at [4].
[4] V1/8A – D Lothian 26.10.2021 at [5].
[5] V1/8A – D Lothian 26.10.2021 at [5].
[6] V1/8A – D Lothian 26.10.2021 at [7].
[7] V1/8A – D Lothian 26.10.2021 at [6].
[8] V4/95 – New South Wales Criminal History – Bail Report generated 13 August 2021 (**NSW Criminal History**).
[9] V4/95 – NSW Criminal History.
[10] V4/95 – NSW Criminal History.
[11] V1/8A – D Lothian 26.10.2021 at [9].
[12] V1/8A – D Lothian 26.10.2021 at [9].

Mental health

14. According to his mother, Mr Lothian was diagnosed with depression in around 2003.[13] She also believes Mathew was 'borderline schizophrenic', stating there were times when 'his mood would change dramatically and then he would be back to normal'.[14]
15. Mr Lothian's Justice Health and Forensic Medicine Network (**Justice Health**) file records a diagnosis of depression dated 23 December 2013.[15] Further, it appears from his Justice Health file that he had been prescribed mirtazapine for depression since around 2014.[16] His Justice Health file does not appear to record any diagnoses for any other psychiatric or psychological conditions (including schizophrenia, as is suggested by Ms Lothian).[17]
16. Dr Olav Nielssen, psychiatrist, has conducted a documentary review in respect of Mr Lothian and prepared two expert reports for the purposes of this inquest. In Dr Nielssen's opinion, Mr Lothian likely had a chronic depressive illness as well as a persistent substance use disorder.[18] Dr Nielssen considers it is likely Mr Lothian had a chronic form of depression since around 2013 and suffered an exacerbation of depression in the lead up to his death.[19] According to Dr Nielssen, it seems Mr Lothian was seriously contemplating suicide in the months prior to his death and 'his decision to commit suicide appears to have resulted from both his predicament, in which he quickly realized he could not escape, and the ready availability of the means to suicide'.[20]

Events leading up to 6 January 2021

Remand into custody on 18 September 2020

17. On 12 March 2020, Mr Lothian was sentenced to an aggregate term of imprisonment for 14 months with a non-parole period of 5 months commencing on 9 December 2019 for offences of larceny, assault occasioning actual bodily harm and police pursuit (**the parole offences**).[21] He was released to parole on 8 May 2020.[22]
18. On 18 September 2020, Mr Lothian was charged with common assault and intentionally choke person without consent (**the new charges**).[23] The new charges led to a revocation of

[13] V1/8A – D Lothian 26.10.2021 at [8].
[14] V1/8A – D Lothian 26.10.2021 at [8].
[15] V6/115 – Justice Health Records, Mathew Lothian, pg 69 of 428.
[16] V6/115 – Justice Health Records, Mathew Lothian, pgs 42, 166, 251, 276, 301, 310, 315 and 424 of 428.
[17] There are references at pg 40 of 428 of the Justice Health Records to bipolar and drug-induced psychosis, however these appear to be based on self-reported diagnoses from Mr Lothian in seeking a prescription for Seroquel, as opposed to diagnoses by any medical professionals.
[18] V4/93A – Report of Dr Olav Nielssen dated 22 April 2023, pg 8.
[19] V4/93A – Report of Dr Olav Nielssen dated 22 April 2023, pgs 8-9.
[20] V4/93A – Report of Dr Olav Nielssen dated 22 April 2023, pg 10.
[21] V4/95 – NSW Criminal History.
[22] V4/97 – Warrant for apprehension upon revocation of parole dated 14 October 2020 (Warrant dated 14.10.2020).
[23] V4/96 – Charges H 785641786.

Mr Lothian's parole.[24] Following that revocation of his parole, Mr Lothian's earliest possible release date for the parole offences was 8 February 2021, that is, just over a month after the date of his death.[25] The new charges were listed for hearing at Central Local Court on 4 February 2021.[26]

19. After his remand into custody, Mr Lothian was transferred to the Metropolitan Remand and Reception Centre (**MRRC**) on 20 September 2020. At the time of intake into MRRC, Mr Lothian reported that he had used Diazepam and cannabis in the four weeks prior to his incarceration,[27] and that alcohol and 'ice' were factors in the offending.[28]
20. Mr Lothian remained at MRRC until 9 October 2020, when he was transferred to John Morony Correctional Centre.[29] On 19 October 2020, Mr Lothian was assigned a 'B Medium' classification and it was recommended that he be placed at the SCCC at Nowra.[30]

Transfer to SCCC on 27 October 2020

21. Mr Lothian was transferred to the South Coast CC on 27 October 2020 and remained there until his death on 6 January 2021.[31]
22. Between 27 October 2020 and around 18 December 2020, it appears Mr Lothian was held at the SCCC without incident. At the time of being processed into the SCCC, Mr Lothian reported that he did not have any current thoughts of self-harm or suicide.[32] These statements were subsequently repeated on occasions when Mr Lothian had interactions with correctional centre staff.[33]
23. On 18 December 2020, Mr Lothian advised correctional centre staff he was 'feeling down' and had thoughts of self-harm and suicide. The Case Note Report completed by Services and Programs Officer (**SAPO**) Kelli Hore recorded the following:[34]

> Advised by SAPO Wood that inmate was sitting outside industries visably [sic] upset and reluctant to speak.
>
> Spoke to pod officers and arranged to speak with inmate in interview room. During interview inmate advised he was feeling down. When asked if he had thoughts of self harm, he replied yes. When asked if he had thoughts of suicide, inmate replied yes. When questioned further regarding this plan inmate declined to discuss further. Spoke to Officer Kitching and advised of the disclosure. Advised inmate that I had disclosed the information

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[24] V4/97 – Warrant dated 14.10.2020; Justice Health File, Mathew Lothian, pg 341 of 428.
[25] V4/97 – Warrant dated 14.10.2020.
[26] V4/95 – NSW Criminal History.
[27] V4/99 – CSNSW Case Management File, pgs 93-97.
[28] V4/99 – CSNSW Case Management File, pgs 99-105.
[29] V4/99 – CSNSW Case Management File, pg 40.
[30] V4/99 – CSNSW Case Management File, pgs 28-31, particularly pg 30.
[31] V4/99 – CSNSW Case Management File, pg 82.
[32] V4/99 – CSNSW Case Management File, pg 82.
[33] V4/99 – CSNSW Case Management File, pg 85; V3/100 – CSNSW Case Note Reports, pg 1.
[34] V4/100 – CSNSW Case Note Reports, pg 1.

> he had told me and he stated “no not self harm”. Advised inmate that because he had told me he had thoughts of self harm, I needed to disclose this.
> Spoke with inmate until he left for the clinic and advised that I would touch base with him early next week.

24. Mr Lothian’s disclosure to correctional centre staff resulted in the making of a mandatory notification.[35] An Immediate Support Plan dated 18 December 2020 recorded that Mr Lothian should be required to wear ‘Full RIT attire’ and should be subject to constant electronic observations.[36] He was then transferred to the South Coast CC’s Clinic.[37]
25. The Justice Health file notes of 18 December 2020 record that upon arrival at the Clinic, Mr Lothian said he did not have thoughts of suicide, but ‘in conversation with patient his thought form is all over the place’. It is further recorded in the file notes that Mr Lothian was ‘[u]nable to hold a conversation, kept repeating “Why me?” and “I don’t know what I’m going to do”’.
26. On 19 December 2020, Mr Lothian was reviewed by Risk Intervention Team (**RIT**) staff. Staff recorded that he presented as calm and told them he had no thoughts of self-harm, his statement regarding self-harm being made ‘as he feels he would have issues in the main due to his associations with HA [Hells Angels] OMCG [Outlaw Motorcycle Gang]’. Following his review, Mr Lothian was ‘stepped down to Greens’ and was allowed access to his property. The RIT Management Plan recorded that Mr Lothian would be interviewed regarding ‘[Outlaw Motorcycle Gangs]’ and would be taken off RIT and moved to G-Pod once Justice Health had cleared him. He was given all meals and phone access and no issues were raised. The Justice Health file notes of 19 December 2020 record that Mr Lothian denied thoughts of self-harm and was requesting reclassification into another gaol.
27. An Outlaw Motorcycle Gang Validation Interview was conducted with Mr Lothian on 20 December 2020. During the interview, Mr Lothian reported that he had never been a member of, nor associated with, the Hells Angels Outlaw Motorcycle Gang. When asked why he had previously stated that he was associated with the ‘[Hells Angels Outlaw Motorcycle Gang]’, Mr Lothian responded that his ‘head was everywhere’. Mr Lothian was then advised that as he had no issues, there was no reason he could not return to the Pod. Mr Lothian reportedly said he was fine with that outcome and had no issues.
28. Later on 20 December 2020, Mr Lothian was again reviewed by RIT staff. He reported that he had no thoughts of self-harm and was willing to return to the C-Pod. His threat of self-harm was assessed as ‘nil’ and it was determined that he could return to the C- Pod as a normal inmate. His RIT discharge plan recorded that he should have ongoing contact with

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[35] V4/99 – CSNSW Case Management File, pgs 7-8.
[36] V4/99 – CSNSW Case Management File, pgs 9-10.
[37] V4/100 – CSNSW Case Note Reports, pg 2.

Pod staff as part of ongoing monitoring and should be referred to the SAPO for assistance if required.[38] Mr Lothian was discharged from the clinic at around 1:25 pm.[39]

Injuries sustained on 20 December 2020

29. At around 1:45 pm on 20 December 2020, Mr Lothian was returned to the Clinic to receive medical attention from Justice Health for injuries to his face.[40] CCTV from the SCCC depicts Mr Lothian enter a cell, along with several other inmates. Over the course of about 10 minutes the other inmates and Mr Lothian leave the cell.[41]
30. First Class Correctional Officer Peter FitzGerald reported in his incident report that he observed Mr Lothian who had "clearly been assaulted":[42]
31. In his Inmate Injury Questionnaire, Mr Lothian reported that he was responsible for the injury as he sustained the assault by '[running] into door playing football'. He further reported that he did not consent to Corrective Services NSW (**CSNSW**) gaining access to his medical records in relation to the injury and did not want protection.[43] He later signed a notification of his desire for police not to conduct an investigation into the incident.[44]
32. At around 2:30 pm on 20 December 2020, Mr Lothian was transferred to Shoalhaven District Memorial Hospital for further assessment.[45] A s 24(1) Form was completed in relation to his transfer which recorded that Mr Lothian should be handcuffed and ankle cuffed, and one officer must be armed for the purposes of the transfer.[46]
33. Mr Lothian was discharged from Shoalhaven District Memorial Hospital at around 11:20 pm on 20 December 2020.[47] The Discharge Referral Note records that Mr Lothian had multiple craniofacial contusions and fractures, which were inconsistent with the stated mechanism of "an alleged strike head vs door".[48] His Discharge Plan included a referral for ophthalmology review and attendance at Wollongong Hospital's Emergency Department on 28 December 2020 for clinical review by the Plastics Registrar (with a note that a closed reduction of the nasal bone fracture could be arranged at that time).[49]
34. Upon discharge from the Shoalhaven District Memorial Hospital on 20 December 2020, Mr Lothian was returned to the South Coast CC's Clinic.

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[38] V4/99 – CSNSW Case Management File, pgs 3-4.
[39] V4/100 – CSNSW Case Note Reports, pg 2.
[40] V4/100 – CSNSW Case Note Reports, pg 2.
[41] Digital evidence, tab 1 - CCTV SCCC dayroom
[42] V4/101 – CSNSW Incident Reports at pg 2.
[43] V4/101 – CSNSW Incident Reports, pg 4.
[44] V4/101 – CSNSW Incident Reports, pg 5.
[45] V4/100 – CSNSW Case Note Reports, pg 2.
[46] V4/99 – CSNSW Case Management File, pgs 166-167.
[47] V6/115 – Justice Health Records, Mathew Lothian, pg 61 of 428.
[48] V6/115 – Justice Health Records, Mathew Lothian, pg 61 of 428.
[49] V6/115 – Justice Health Records, Mathew Lothian, pg 62 of 428.

35. On 21 December 2020, Mr Lothian was placed on the waitlist for 'Psych 2 Sub-Acute Suicide / Self Harm' and a Risk Intervention Team review was conducted, following which Mr Lothian was 'stepped down to Greens' with nil issues raised.[50]
36. On 22 December 2020, a Registered Nurse reviewed Mr Lothian in the Clinic. During his consult, Mr Lothian said he wanted to refuse all upcoming appointments and treatment as he did not want to spend any time in the Clinic. Following a discussion with the Registered Nurse, Mr Lothian later indicated he was happy to attend appointments.[51]
37. On 23 December 2020, Mr Lothian was transferred to Nowra to see ophthalmologist Dr Smita Agarwal in relation to his injuries. The s 24(1) Form in relation to this transfer again recorded that Mr Lothian should be handcuffed and ankle cuffed, and that one officer must be armed for the purposes of the transfer.[52] In the 'summary section', the form additionally recorded that a 'retraining [sic] belt was an authorised instrument of restraint for the purposes of the transfer'.[53]
38. On 28 December 2020, Mr Lothian was transferred to Wollongong Hospital for an appointment with an oral and maxillofacial surgeon.[54] Again, the s 24(1) Form for this transfer recorded that Mr Lothian should be handcuffed and ankle cuffed, and that one officer must be armed for the purposes of the transfer. Further, the 'summary section' of the form additionally recorded that a 'retraining [sic] belt was an authorised instrument of restraint for the purposes of the transfer'.[55] As a result of this surgical consultation, it was determined that Mr Lothian would be admitted for surgery for a closed reduction of his nasal fracture.[56] Mr Lothian underwent surgery and returned to the SCCC at around 8:00 pm that evening. The Justice Health file notes of 28 December 2020 record that Mr Lothian was to attend a follow up appointment at the Plastics Clinic at Wollongong Community Health Centre, within the Piccadilly Centre on 6 January 2021.[57] A Health Problem Notification Form was completed by Registered Nurse Maddison Miller prior to Mr Lothian's return from hospital which recorded, among other things, that Mr Lothian had a 'history of mental health' and should be observed for isolative behaviour, agitation or mood swings.[58]
39. On 29 December 2020, Mr Lothian was reviewed in the Clinic by a Registered Nurse. The Justice Health file notes record that Mr Lothian was 'low in mood' and stated, *'why do bad things keep happening to me'*. The notes further record that the afternoon staff were advised

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[50] V4/100 – CSNSW Case Note Reports, pgs 2-3.
[51] V6/115 – Justice Health Records, Mathew Lothian, pg 382 of 428.
[52] V4/99 – CSNSW Case Management File, pgs 149-151 at 150.
[53] V4/99 – CSNSW Case Management File, pgs 149-151 at 151.
[54] V6/115 – Justice Health Records, Mathew Lothian, pg 390 of 428.
[55] V4/99 – CSNSW Case Management File, pgs 134-136.
[56] V6/115 – Justice Health Records, Mathew Lothian, pg 391 of 428.
[57] V6/115 – Justice Health Records, Mathew Lothian, pg 394 of 428.
[58] V4/101 – Incident Reports – December 2020, pg 10.

about Mr Lothian's mood and a welfare check was to be conducted that evening.[59] On the evening of 29 December 2020, a welfare check was conducted with no issues voiced.[60]

40. On 30 December 2020, Mr Lothian was assessed by CSNSW Senior Psychologist Amy Sowerby in response to the 'Psych 2 Sub-Acute Suicide / Self Harm referral' made on his behalf on 20 December 2020.[61]
41. Between 31 December 2020 and 3 January 2021, Mr Lothian was regularly monitored by Justice Health staff in the Clinic. The Justice Health file notes for those dates generally record that Mr Lothian did not voice any concerns.[62]
42. On 4 January 2021, Ms Sowerby again saw Mr Lothian.
43. On 5 January 2021, Mr Lothian was seen in the Clinic by Justice Health staff. The Justice Health file notes record that Mr Lothian said he was happy to attend his medical appointment on 6 January 2021 and did not voice any further issues.[63]

Gaol calls with his mother

44. Mr Lothian had regular telephone contact with his mother whilst in custody and in the three weeks prior to his death; he called her every day. Mr Lothian's low mood is a consistent theme across the recorded gaol calls. On 27 December 2020, he told his mother *'[i]t just gets worse and worse doesn't it mum?'* to which his mother replied, *'what's that?'* and Mr Lothian responded, *'just over it mum… just everything, I'm over it… Life… you know'*.[64]
45. In a call on the morning of his death, Mr Lothian told his mother, *'I'm just over it…I'm over it…why me mum…Done. I'm over it. I'm over everything'*.[65] Ms Lothian has said her son sounded 'very sad' during his phone call to her on the morning of his death. She has said, 'Call it mothers' intuition but I knew something was going on with him as he didn't seem right'.[66]
46. Mr Lothian did not disclose what stressors lay behind his comments to his mother. In some of the gaol telephone calls, Mr Lothian made comments that suggest the possibility he felt abandoned by his family or that family members, particularly his brother, did not truly hold him in their affections.[67] There is also the fact of his longstanding drug problems and frequent incarceration, as well as his diagnosed depression. In addition, there is the fact of his facing allegations of having committed a very serious offence of violence.

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[59] V6/115 – Justice Health Records, Mathew Lothian, pg 397 of 428.
[60] V6/115 – Justice Health Records, Mathew Lothian, pg 398 of 428.
[61] Statement of Amy Sowerby dated 14 June 2024, [12].
[62] V6/115 – Justice Health Records, Mathew Lothian, pgs 401-406 of 428.
[63] V6/115 – Justice Health Records, Mathew Lothian, pg 410 of 428.
[64] V5/102 – Prison Telephone Transcripts – 3 December 2020 to 6 January 2021, pgs 98-99.
[65] V5/102 – Prison Telephone Transcripts – 3 December 2020 to 6 January 2021, pgs 1-2.
[66] V1/8A – D Lothian 26.10.2021, [12].
[67] See, for example, V5/102 – Prison telephone transcripts at pgs 10, 36-37, 49, 72, 100, 118, 120, 123-124, 125, 149, 170, 242.

The events of 6 January 2021

47. Following his surgery on 28 December 2020, Mr Lothian was scheduled to attend a follow up appointment in Wollongong at 12:50 pm on 6 January 2021.[68]
48. On 30 December 2020, the acting Functional Manager of Security at the South Coast CC, Jose Noronha completed and signed a s 24(1) Form authorising Mr Lothian's transfer to the Piccadilly Centre in Wollongong on 6 January 2021.[69] That same day, the Acting Manager of Security at the SCCC, Ms Amanda Buck approved and signed the transfer.[70]
49. The form they completed recorded that Mr Lothian was to be transferred from the SCCC at 10:30 am on 6 January 2020 and was to return on completion of treatment. The appointment location was identified as Unit 28-29 Piccadilly Centre, 341 Crown Street, Wollongong. The form recorded that Mr Lothian was to remain in the company of a correctional officer at all times, be handcuffed and ankle cuffed, and that one officer must be armed. Under the heading 'Part 3. Summary', the form recorded that handcuffs, ankle cuffs, a restraining belt and one firearm were 'authorised instruments of restraint' for the purposes of the transfer.[71]
50. On the morning of 6 January 2021, Mr Lothian was reportedly reluctant to attend his appointment. According to Nurse Colleen Lasker, a Correctional Services Officer approached her at around 10:30 am and told her that Mr Lothian did not want to attend his appointment, was agitated and wanted to return to his pod.[72] Nurse Lasker had a good rapport with Mr Lothian so went to his cell to speak with him. Upon speaking to Mr Lothian, he told her he wanted to go back to his pod. Nurse Lasker recalled that she explained to Mr Lothian that he required medical clearance from the General Practitioner before he could go back to the pod and the General Practitioner would be attending the Clinic on Friday. She also told Mr Lothian it was important for him to attend the appointment as he had multiple unstable facial fractures that required specialist treatment. Mr Lothian then agreed to attend the appointment and Nurse Lasker observed Mr Lothian to be calm as he walked to the reception to be escorted to his appointment.[73]
51. Registered Nurse Maddison Miller was present at the time of this interaction. Her recollection of the interaction with Mr Lothian is consistent with that of Nurse Lasker. She recalled that after Nurse Lasker spoke to Mr Lothian, she (Nurse Miller) told him words to the effect, *'it's*

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[68] V6/115 – Justice Health Records, Mathew Lothian, pg 394 of 428; V2/21 – Statement of Corrective Services Investigator Glen Phillips signed 16 February 2021, pg 26 (NSW Health Request for Unplanned Transfer for Healthcare form dated 29 December 2020).
[69] V1/10 – s 24(1) Transfer Order for 6 January 2021; V2/18 – Statement of Jose Noronha signed 19 March 2021, [4].
[70] V1/10 – s 24(1) Transfer Order for 6 January 2021; V2/22 – Statement of Amanda Buck signed 19 March 2021.
[71] V1/10 – s 24(1) Transfer Order Corrective Services.
[72] V4/73 – Statement of Colleen Lasker signed 25 February 2021 (**Lasker 25 02.2021**), [10].
[73] V4/73 – Lasker 25.02.2021, [10]-[13]; See also entry made by Nurse Lasker on Mr Lothian's Justice Health file at V6/115 – Justice Health Records, Mathew Lothian, pg 411 of 428.

important to attend your appointment to be medically cleared to go back to the yard', following which Mr Lothian agreed to attend the appointment.[74]

Transfer to the Piccadilly Medical Centre

52. Correctional Services Officers Michael Greer and Glenda Harvey were responsible for conveying Mr Lothian to his scheduled appointment. At around 8:30 am on 6 January 2021, CSO Greer and CSO Adam Chalker attended the Clinic and informed Mr Lothian that he was being escorted to his scheduled appointment. CSO Chalker recalled that Mr Lothian wanted to return to the yard and that it 'took a while for the nursing staff to convince Lothian that he needed to go'.[75]
53. CSO Greer and CSO Chalker conducted a strip search of Mr Lothian which was clear and then applied hand and ankle cuffs to Mr Lothian (with CSO Chalker reapplying the ankle cuffs to Mr Lothian after CSO Greer had initially applied them upside down). A restraining belt was not utilised. CSO Greer and CSO Chalker then walked Mr Lothian to the escort van and CSO Chalker returned to Reception.[76]
54. CSO Greer placed Mr Lothian inside the escort van where Mr Lothian sat inside the metal compartment, which was locked by CSO Harvey. At around 10:45 am, they left the South Coast CC and drove to the Piccadilly Centre in Wollongong.[77]
55. According to CSO Harvey, she collected the escort van from the carpark and drove it to Reception. She also collected an escort kit bag, which contained a spare set of keys, a restraining belt and a clipboard holding the relevant documents. She has said she recalls checking the paperwork with CSO Greer upon receiving it. She and CSO Greer then collected Mr Lothian from Reception. Mr Lothian had already been strip searched and had hand and ankle cuffs applied. Mr Lothian then entered the metal compartment of the van and CSO Harvey locked the metal compartment and closed the sliding door. They then drove out of Reception and collected a firearm and mobile phone from [redacted]. Upon collecting the firearm, CSO Harvey placed it into her holster.[78]
56. They then travelled directly to the Piccadilly Centre in Wollongong, with CSO Harvey driving and CSO Greer seated in the front passenger seat.[79] During the drive, CSO Greer observed Mr Lothian via CCTV and has said he sat quietly for the duration of the trip with his head in his hands.[80]

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[74] V4/74 – Statement of Maddison Miller signed 23 June 2021, [10].
[75] V1/25 – Statement of Adam Chalker signed 19 March 2021 (**Chalker 19.03.2021**), [5].
[76] V2/25 – Chalker 19.03.2021, [6]-[7].
[77] V1/9 – Statement of Correctional Services Officer Michael Greer signed 6 January 2021 (**CSO Greer 06.01.2021**), [5]-[8].
[78] V2/12 – Statement of Correctional Services Officer Glenda Harvey signed 12 January 2021 (**CSO Harvey 12.01.2021**), [4]-[10].
[79] V2/12 – CSO Harvey 12.01.2021, [4]-[10].
[80] V1/11 – Transcript of Michael Greer's Walk-Through recorded 17 January 2021 (CSO Greer Walkthrough 17.01.2021), pg 15.

Arrival at the Piccadilly Centre, seizure of firearm and shooting

57. What occurred when they arrived at the Piccadilly Centre will be a significant focus of these findings. The two critical witnesses to those events are CSO Harvey and CSO Greer. At this point I will briefly address the evidence of CSO's Harvey and Greer, and I will return to their evidence later in these findings.
58. CSO Harvey provided a statement to police on 12 January 2021 and later participated in a walkthrough with police at the scene on 17 January 2021. She also participated in an electronically recorded interview with Corrective Services Investigators at the South Coast CC on 19 February 2021.
59. CSO Harvey has recalled that they arrived at the Piccadilly Centre at about 12:05 pm. She parked the van on the southern side on the ground level of the car park and then she and CSO Greer exited the van. CSO Greer positioned himself at the passenger side back corner of the van while CSO Harvey opened the sliding door. According to CSO Harvey, CSO Greer was close to the door at the time and she did not fully slide the door open. At this point, CSO Harvey unlocked the inner hinged door padlock and the door 'swung out past the side of the van'. After a brief delay, Mr Lothian stepped up and moved forward onto the step of the van and then made a small jump off the step onto the ground, stumbling a little when he hit the ground.[81]
60. CSO Harvey has provided the following account of the events that immediately followed:[82]

> [12] I saw LOTHIAN make a small swivel of his body and shuffle forward and slightly sideways to the left in Officer GREERS [sic] direction, so I was able to shut the hinged door and close the sliding door with my left hand. I was about to lock the van using the vehicles [sic] remote however LOTHIAN lunged at me and to the best of my knowledge a brief struggle ensued, and I can remember feeling pressure on my firearm holster which was in my right hip. The holster has one small press button which sits near the top strap. I cannot recall the exact events at that time, but I clearly remember hearing the noise of the van keys landing somewhere close to me. I think I was knocked to the ground by LOTHIAN, but that period of time is blank, and I don't know what happened. My next clear memory was that I got up of [sic] the ground and I was standing halfway up close to the front of a civilian vehicle parked next to our van. I looked up toward the rear of the escort van and I saw LOTHIAN pointing the firearm at me. It was only at this point I realised LOTHIAN had taken the weapon from my holster. I slowly retreated away from him in a semi crouched position over to the front of the civilian vehicle which was parked with the front of the vehicle facing south.

[81] V2/12 – CSO Harvey 12.01.2021, [10]-[11]. See, also, V2/13 – Transcript of Glenda Harvey's Walk-Through recorded 17 January 2021.

[82] V2/12 – CSO Harvey 12.01.2021, [12]-[14]. See, also, V2/14 – Transcript of Triple Zero Call made by Glenda Harvey dated 6 January 2021.

[13] While I was moving, I pulled out the work mobile and called 000. Simultaneously LOTHIAN moved parallel to me and positioned himself at the rear of the civilian vehicle to a point where he was looking through the rear window and windscreen at me. I saw him pointing the firearm at me the whole time that he was in that position.

LOTHIAN yelled "Give me the keys"

I said, "I don't have the keys"

LOTHIAN yelled "Give me the keys"

I said, "I don't have the keys"

[14] At that time, I had been able to speak to only the 000-switch operator however I was not successful in speaking to a Police dispatch officer, so I stayed on the phone. I remained in that position until I heard two shots fired and I realised LOTHIAN had moved his position in the carpark to the entry/exit entrance of the carpark of the medical centre. I immediately thought that LOTHIAN had shot Officer GREER because I knew Officer GREER had headed out towards that direction.

61. CSO Greer made a statement to police on 6 January 2021 and later participated in a walkthrough at the scene with police on 17 January 2021. He was interviewed by Corrective Services Investigators on 24 March 2021.
62. CSO Greer's recollection of Mr Lothian's exit from the van and seizure of the firearm from CSO Harvey is recorded in his first statement as follows:[83]

[10] I hoped [sic] out of the front passenger side door; I walked to the left sliding door of the van and opened it, as Glenda exited the driver's side door and walked around to the rear. Glenda unlocked the compartment for the inmate and then proceeded to walk to the left front side of the vehicle. She was facing me. I asked the inmate to exit the vehicle, which he did, I then asked him to come down with me, indicating to walk to the rear left side which he did. I made sure we had about a meter distance between us. He was positioned between me and Glenda. I looked downwards as I took my gloves out of my pocket to put them on when out of the corner of my eyes, I saw that he was moving. I looked up immediately and saw that he had lunged towards Glenda, who was standing within a couple of meters away from him.

[11] I immediately ran towards the inmate, his back was towards me and I could see that he was grabbing at her firearm, Glenda was yelling out words like, "let go" and "stop" and I could see she was trying to prevent him from grabbing it. She was wrestling with him then as I reached them, LOTHIAN turned around and pointed a firearm at me, he said, "Give them, give them", I assumed he was asking for keys to unlock his cuffs.

[12] I immediately placed my hands in the air and said "Woo" and started walking backwards, I created about a three-meter [sic] gap between me and he [sic] inmate. I walked past the rear of the car and was walking back towards Gladstone Avenue (out of the carpark).

[83] V1/9 – CSO Greer 06.01.2021, [10]-[14]. See, also, V1/11 – CSO Greer Walkthrough 17.01.2021.

> [13] The inmate appeared to focus his attention back inside the carpark towards where Glenda had been (front left of the vehicle) and turned and pointed the firearm in that direction. I exited the carpark and immediately called 000, I spoke to the operator and before I could get through to the Police, I heard what I believe was two-gun shots.
>
> [14] I hung up the call, I started to walk back down Gladstone towards the carpark fearing that Glenda may have been injured, I stopped and thought how I wasn't armed and called 000 immediately back.

63. Whilst on the phone to triple-0, CSO Greer ducked into a laneway off Gladstone Street and positioned himself behind a parked car such that he was able to look back out onto Gladstone Street.[84] He has said that about a minute later, he saw Mr Lothian standing near the entrance to the carpark and heard him asking two passers-by for help. CSO Greer then observed Mr Lothian raise his arms and point the firearm north on Gladstone, as if 'he was trying to threaten someone'. Mr Lothian then dropped his arms down before raising them again and firing gun shots into the street, followed by one further shot.[85]
64. CSO Greer provides the following recollection of what happened next:[86]

> About 15 seconds later I saw the firearm was still in both his hands, he placed the nozzle of the firearm under his neck and jaw area, his facial expression looked like he was distressed and frantic. I then heard one gunshot, I remained looking at him the entire time through the glass windows of the car, I was hiding behind, I saw him fall to the ground. He was lying on his back at the entrance way, I could see that he was still holding the firearm in both his hands which were resting on his stomach area.

65. CSO Greer slowly approached Mr Lothian and observed blood coming from the back of his head and neck. A few seconds later, a police officer ran over and kicked the firearm out of Mr Lothian's hands and a second officer arrived. CSO Greer told the police that he was from Corrective Services and that he was going to go and check on his partner.[87] CSO Greer later assisted police in rendering first aid to Mr Lothian by placing a bandage around Mr Lothian's neck.[88]
66. While CSO Greer was observing Mr Lothian from outside the carpark, CSO Harvey remained hidden within the carpark on the phone to the triple-0 operator. She remained near the escort van in the carpark until she heard CSO Greer say, *'The crim just shot himself we're fine we're fine'*. She and CSO Greer then exited the carpark where she observed a heavy presence of police and paramedics who were attending to Mr Lothian. CSO Harvey then spoke with a

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[84] V1/9 – CSO Greer 06.01.2021, [15].
[85] V1/9 – CSO Greer 06.01.2021, [17].
[86] V1/9 – CSO Greer 06.01.2021, [18].
[87] V1/9 – CSO Greer 06.01.2021, [19].
[88] V1/9 – CSO Greer 06.01.2021, [21].

few detectives at the scene before being taken to Wollongong Hospital for treatment for some abrasions, bruises and shock.[89]

67. CSO Harvey and CSO Greer's oral evidence given at the inquest as to the events of 6 January 2021 was consistent with their prior statements and interviews.

CCTV

68. CCTV captures the escort van enter the Piccadilly Centre multistorey carpark at about 11:56am.[90] Although there were CCTV cameras inside the Piccadilly Centre carpark, unfortunately what happened next was not captured on CCTV.
69. Following the escort van entering the carpark, the next portion of CCTV depicts CSO Greer running from the carpark towards Gladstone Avenue.[91] A few moments later Mr Lothian is depieced walking around inside the carpark with both of his arms to his front.
70. Mr Lothian then walks onto Gladstone Avenue. A car pulls up and parks on Gladstone Avenue, adjacent to where Mr Lothian was standing. Mr Lothian appears to interact with the driver of the car. The driver of the car walks away from Mr Lothian, and Mr Lothian situates himself on a driveway between the Piccadilly Centre carpark and Gladstone Avenue.
71. A marked police car approaches the area where Mr Lothian is standing. The police vehicle stops, briefly, before driving quickly in reverse.
72. CCTV from the driveway where Mr Lothian positioned himself depicts Mr Lothian raising the firearm to chest height and discharging it. The CCTV does not depict towards who or what Mr Lothian was shooting at. A few moments after discharging the firearm, Mr Lothian is depicted placing the nozzle of the firearm under his chin, before he collapses to the ground and begins to bleed heavily.[92]
73. Shortly after Mr Lothian collapses, CSO Greer, who had been hiding in a garage adjacent to where Mr Lothian was standing, steps out onto Gladstone Avenue and waves. He appears to be holing a mobile phone up to his ear. A few moments later police officers approach Mr Lothian and CSO Greer. One of the officers kicks the firearm out of Mr Lothian's hand.
74. Additional police arrive on the scene and provide first aid to Mr Lothian. Paramedics then arrive and commence treating Mr Lothian.

Civilian accounts

75. There were many civilians present in and around the medical centre who witnessed the incident.
76. Of particular note are the following civilian accounts:

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[89] V2/12 – CSO Harvey 12.01.2021, [15]-[20].
[90] V1/8 – DSGT Joerdens, p 120.
[91] Ex 1, digital evidence, tab 13
[92] Ex 1, sensitive digital evidence, tab 1

a. Matthew Chessell was walking through the carpark when he encountered Mr Lothian. He recalls that he was about halfway out of the carpark when he heard a male voice say, ‘Hey bro’. Mr Chessell turned around and saw Mr Lothian standing about four to five metres away from him holding a silver pistol in both hands. He observed Mr Lothian to be ‘angry and wide eyed’ and concluded he may have been under the influence of drugs. Mr Lothian asked him whether he had a car, to which Mr Chessell replied he did not. Mr Chessell turned and walked away towards Gladstone Avenue. As he walked down Gladstone Avenue, Mr Chessell observed a police car and assumed that someone must have already alerted the police. As he continued walking along Gladstone Avenue, he heard two gun shots. He jumped for cover behind a brick wall, assuming that Mr Lothian was shooting at him or other civilians. Mr Chessell later walked back up Crown Street and saw Mr Lothian lying on the ground, bleeding from his neck.[93]

b. Brent Quakawoot encountered Mr Lothian as he walked along Gladstone Avenue towards Crown Street. He observed a male wearing ‘prison greens', holding his hands in front of him ‘like he was trying to hide his hands’. Mr Lothian politely asked Mr Quakawoot for a lift, to which Mr Quakawoot replied, *‘I can’t, I’ve got to go this way’*. Mr Lothian then asked Mr Quakawoot for his keys while pointing the gun at him. In response, Mr Quakawoot walked backwards away from Mr Lothian while stating, *‘I can’t give you the car man’*, *‘No you’re not taking my car, it’s the only car I got’*. Mr Quakawoot told Mr Lothian that he was ‘also on the run from the cops’ and advised Mr Lothian to run away and hide. In response, Mr Lothian thanked him and went back towards the corner. Mr Quakawoot then went around the corner and heard gunshots. According to Mr Quakawoot, Mr Lothian was not angry and did not swear, and he did what Mr Quakawoot told him to do.[94]

Police accounts

77. At the time of the incident, Senior Constable Brenton Ward was driving north along Gladstone Avenue. He had turned left at the intersection of Gladstone Avenue and Crown Street when he was waved down by two pedestrians who said, *‘There’s a guy just down the street running around with a gun’*. SC Ward conducted a U-Turn on Crown Street and activated his warning devices. As SC Ward travelled back along Gladstone Avenue, he observed Mr Lothian approximately 20 to 30 metres away ducking in and out of vehicles. He observed Mr Lothian to be wearing prison greens, with his hands and ankles cuffed. He also noticed that Mr Lothian was holding a silver pistol in both hands.

[93] V4/82 – Statement of Matthew Chessell signed 6 January 2021, [5]-[9].
[94] V4/84 – Statement of Brent Quakawoot signed 6 January 2021, [4]-[8].

78. SC Ward has provided the following account of the events that transpired next:[95]

> [9] I noticed that the male was laughing. He raised the pistol to chest height and pointed it at my vehicle. I immediately tried reversing my car. The male fired a single shot from the pistol. The round penetrated the lower centre of the windscreen of my vehicle and into my vehicle's dashboard.
>
> [10] After the male had fired the shot, he ran south on Gladstone Avenue and made a sharp left hand turn into an alley way.
>
> [11] I called for urgent assistance on the Police Radio by stating *'Shots fired Gladstone Avenue'*. Or words to that affect [sic]. I got out of the car and ran to the back of the vehicle to seek appropriate cover.
>
> [12] I tried moving on some bystanders that here [sic] at the intersection of Gladstone Avenue and Crown Street. I also requested through Police Radio that a perimeter be established as I didn't know where the male had gone.
>
> [13] Whilst this was happening, I heard a second shot.
>
> I heard someone yell – *'Someone's been shot.'*
>
> [14] I drew my Police pistol and ran towards the parked vehicle that the male had been ducking in and out of beforehand. At this point I saw a male corrective services officer walk out of the alley way that the male had ran into. The correctives officer was on the phone.
>
> [15] I saw the male that had fired a shot at my vehicle laying on his back in the alley. He had what appeared to be a gunshot wound to his neck. Blood was running from his mouth and he was convulsing.
>
> I asked the correctives officer – *'Did you shoot him?'*
>
> He said – *'No I think he shot himself.'*
>
> [16] The male still had the pistol on his hands held at his waist. I kicked the pistol from his hands. Shortly after, further police began arriving at the scene and began rendering aid to the male. I continued to communicate with Police Radio.

79. In the aftermath of the incident, many other police attended the scene. In large part, those officers did not directly witness the incident and their statements provide corroborative accounts of the scene and what transpired after Mr Lothian shot himself.

Accounts of Ambulance NSW personnel

80. Paramedics arrived at the scene at around 12:07pm.[96] Their assessment of Mr Lothian revealed that he was unconscious and had a very weak pulse and 'agonal respirations',

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[95] V3/28 – Statement of Senior Constable Brenton Ward dated 6 January 2021 (**SC Ward 06.01.2021**), [4]-[16]. See, also, V3/29 – Body Worn Video Transcript dated 6 January 2021.

[96] V4/71 – Statement of James Clark signed 26 June 2021 (**Clark 26.06.2021**), [5]-[6].

where he was taking a breath every 5 to 6 seconds. Mr Lothian went into cardiac arrest, and CPR was commenced.[97]

81. At around 12:25 pm, Dr James Bliss of the NSW Ambulance Aeromedical Operations unit arrived on the scene. Dr Bliss commenced infusion of packed red blood cells while receiving a handover from the paramedics already present. Dr Bliss was informed that Mr Lothian had sustained a single wound to the neck, that paramedics had been treating on scene for 25 minutes and that Mr Lothian had been in cardiac arrest for 8 minutes. Dr Bliss observed that paramedics had utilised an endotracheal tube and intravenous cannula and had commenced advanced life support resuscitation with chest compressions and administration of intravenous adrenaline.[98]
82. Upon assessing Mr Lothian, Dr Bliss determined that based on the injury sustained and the progression to cardiac arrest, the injury was unsurvivable. Dr Bliss determined that resuscitation should cease, and he pronounced Mr Lothian deceased at 12:30 pm.

Postmortem examinations

83. On 8 January 2021, Dr Kendall Bailey, Forensic Pathologist, performed a postmortem examination on the deceased. Also present at the postmortem were Detective Sergeant Lynch, Crime Scene Officer Whitehead, Ballistics Officers Bolton and Bohora and Detective Senior Constable Hayley Graham from the Wollongong Police District. Dr Bailey concluded that Mr Lothian died from a self-inflicted gunshot wound to the neck and head.[99]
84. The wound track travelled through the oropharynx and continued into the cranial cavity with the projectile coming to rest at the left parietal region immediately below the dura with an associated 35 x 10 mm laceration of the dura (60 mm of the midline), a 30 x 6 mm bony defect and surrounding soft tissue haemorrhage.[100]
85. Toxicological analysis detected the presence of methadone and non-toxic blood levels of mirtazapine and paracetamol. No alcohol, additional common medications or drugs of abuse were identified.[101]

Key issues considered at the inquest

86. The issues to be explored as part of my statutory task to inquire into and make the findings required by s 81 of the Act are connected to the uncertainty that remains as to the facts and circumstances leading up to Mr Lothian's seizure of CSO Harvey's firearm.
87. A list of issues dated 30 July 2024 to be explored at the inquest was provided to the interested parties which listed the following issues:

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[97] V4/71 – Clark 26.06.2021, [7]-[8].
[98] V4/93 – Statement of James Michael Bliss signed 10 August 2021 (**Bliss 10.08.2021**), [5].
[99] V1/7 – Autopsy report of Dr Kendall Bailey 26 July 2021, 3.
[100] V1/7 – Autopsy Report dated 26 July 2021, pg 9.
[101] V1/7 – Autopsy Report dated 26 July 2021, pg 4.

1. What particular stressors impacted upon Mr Lothian's state of mind and decision-making which might have precipitated or contributed to his decision to take his own life? In particular, what, if any, stressors lay behind Mr Lothian's comments to his mother in the gaol telephone call transcripts? (**Issue 1 – Mr Lothain's state of mind)**

2. Whether adequate medical treatment and monitoring was provided to Mr Lothian given his mental health concerns, specifically: (**Issue 2 – the adequacy of medical treatment and monitoring**).

a. Whether the initial response to Mr Lothian's disclosure of thoughts of self-harm and suicide of 18 December 2020 was adequate (namely, his placement in the Clinic on RIT between 18 and 20 December 2020, before being returned to the Pod).

b. Whether the referral to Psychology and subsequent attendances by Psychology on Mr Lothian on 30 December 2020 and 4 January 2021 were adequate.

c. Whether any feature(s) of the "Form 2A: Psychology Participant Information" Mr Lothian was told on 30 December 2020 he was required to sign in order to speak with a psychologist within Corrective Services NSW (CSNSW) may have presented a barrier to him seeking and receiving assistance for the mental health issues he was experiencing.

d. Whether an adequate risk assessment was undertaken before Mr Lothian was medically escorted on 6 January 2021 considering his mental health concerns.

3. The adequacy of the medical escort of Mr Lothian on 6 January 2021, specifically: (**Issue 3 – the adequacy of the medical escort on 6 January 2021**).

a. Whether a risk assessment should have been undertaken before Mr Lothian was medically escorted on 6 January 2021, having regard to Custodial Operations Policy and Procedure (COPP) 19.6 (Medical Escorts) and COPP 19.1 (General Escort Procedures).

b. The reasons, if any, the Manager of Security did not conduct a pre-escort briefing with CSO Harvey and CSO Greer on 6 January 2021 as required by COPP 19.6 (Medical Escorts) at [2.1].

c. Whether a restraining belt ought to have been applied to Mr Lothian for the purposes of the escort, having regard to COPP 19.6 (Medical Escorts) at [2.5].

d. Whether the actions of CSO Greer and CSO Harvey were appropriate during the medical escort. In particular:

i. Whether CSNSW policies and procedures regarding the use of restraining belts during medical escorts (specifically, COPP 19.6 (Medical Escorts) at [2.5]); and

ii. Whether CSNSW policies and procedures regarding the use and securing of firearms for the purposes of medical escorts (specifically, COPP 19.6 at [2.4]) were followed, noting that Mr Lothian was able to seize CSO Harvey's firearm while hand and ankle cuffed.

e. Whether CSO Greer and CSO Harvey were familiar with conducting medical escorts and the CSNSW policies and procedures relating to medical escorts.

f. Whether CSO Greer and CSO Harvey had been adequately trained in the applicable CSNSW policies and procedures relating to medical escorts.

g. Whether, having regard to the events of 6 January 2021, CSNSW policies and procedures regarding medical escorts are adequate in respect of the identification and assessment of associated risks, the use of restraining belts and the use and securing of firearms.

4. Whether the firearm and holster issued to CSO Harvey on 6 January 2021 was appropriately assessed as to its condition before being issued to her, specifically: (**Issue 4 – firearm and holster**).

a. Whether the holster issued to CSO Harvey on 6 January 2021 had the mechanisms referred to in the document at Tab 113 of the brief entitled 'Understanding Holster Retention Methods' and if so, whether CSO Harvey was aware of how to use them.

b. Whether the holster was in a proper condition for use by a Correctional Officer conducting a medical escort, noting the expert opinion of Detective Technical Sergeant Connie Maree Lynch.

c. Whether CSNSW policies and procedures regarding the inspection of firearms and other security equipment were complied with in respect of the firearm and holster issued to CSO Harvey on 6 January 2021.

d. Whether CSNSW policies and procedures regarding the inspection of firearms and other security equipment are adequate, having regard to the events of 6 January 2021.

Issue 1 – Mr Lothian's state of mind

88. As referred to earlier in these findings, Dr Olav Nielssen, psychiatrist, has conducted a documentary review in respect of Mr Lothian and prepared two expert reports for the purposes of this inquest. Dr Nielssen also gave evidence at the inquest.
89. Dr Nielssen opines that it seems likely that Mr Lothian had a chronic depressive illness as well as a persistent substance use disorder. Mr Lothian had been diagnosed with depression by doctors and was prescribed mirtazapine at a moderate dose of 45 mg. He disclosed thoughts of suicide and was observed to be in tears and to appear depressed in the days and weeks prior to his death. It is also possible that he had torn up bed sheets in preparation for a suicide attempt on 23 November 2020. Dr Nielssen considers Mr Lothian's depressive illness was probably severe, based on descriptions of his behaviour, his disclosure of suicidal thoughts, what may have been a plan to attempt suicide and the tone of his voice in audio recordings.[102]
90. As to the particular stressors which impacted upon Mr Lothian's state of mind in the weeks leading up to his death, Dr Nielssen opines that Mr Lothian is likely to have suffered an exacerbation of depression in the leadup to his death. Dr Nielssen notes that Mr Lothian rang the prison mental health line on day twelve of the two weeks of Covid quarantine in force at that time, asking to have his antidepressant medication reinstated. Further, the disclosure of

[102] Tab 93A, p 8.

thoughts of suicide to a prison officer was significant, as doing so would be associated with significant inconvenience of being placed in an observation cell and being subjected to a RIT. Dr Nielssen considers that the possibility that Mr Lothian faced a serious predicament and threats within the prison is raised by his disclosure of suicidal thoughts, which would have the inevitable consequence of being placed in an observation cell, his disclosure of an association with the Hells Angels, which was not confirmed, but might have led to transfer, and also his direct request for transfer to another prison. That possibility is supported by the sequence of events, as he was assaulted by a group of men, including an affiliate of a notorious middle eastern gang soon after he returned to his wing.[103]

91. Dr Nielssen said in evidence the fact a person with Mr Lothian's history or previous terms of imprisonment made such a disclosure, knowing that it would likely result in a RIT tended to support a conclusion the thoughts of suicide he expressed on 18 December 2020 were genuine.
92. Dr Nielssen considers Mr Lothian was exhibiting suicidal intent / ideation in the period leading up to his death and on the day of his death, relying on the incident report of having torn up bedsheets on 23 November 2020, and Mr Lothian's disclosure of thoughts of suicide on 18 December 2020, which suggest that he had persistent and serious thoughts of suicide for some time prior to his death.[104]
93. More generally, Dr Nielssen notes that the effect of Mr Lothian's substance use and the constant setbacks associated with self-defeating behaviour are likely to have contributed to becoming depressed and to the persistence of symptoms of depression.[105]
94. Ultimately, however, Dr Nielssen concludes that the events leading up to Mr Lothian's death appear to be an attempted escape committed on impulse. His oral evidence was that Mr Lothian's criminal history and the events leading up to his death disclose that he was a person who acted on impulse or without proper planning and whose mood state fluctuated in accordance with external events. He also noted that Mr Lothian had earlier that day expressed a desire to not go on the escort, which supported the proposition that the attempted escape was likely an impulsive act.
95. That said, Dr Nielssen said that it seemed Mr Lothian was seriously contemplating suicide in the months leading up to his death, and Mr Lothian's decision to end his life appears to have resulted both from his predicament, in which he quickly realised he could not escape, and the ready availability of the means to suicide.[106] In oral evidence, he elaborated that prisoners have a high rate of suicide in general.

[103] Tab 93A, p 9.
[104] Tab 93A, p 9.
[105] Tab 93A, p 10.
[106] Tab 93A, p 10.

96. I am satisfied, given the CCTV and eyewitness observations, that when Mr Lothian pulled the trigger of the firearm having put it in a position where it was pointed upwards under his own chin, he did so with the intention of ending his own life. That intention can be inferred from the high degree of certainty that death will occur in the ordinary course of events where a person discharges a firearm aimed at close range to their own head.
97. I accept Dr Nielssen's evidence and that the events leading up to Mr Lothian's death appear to be an attempted escape committed on impulse and that Mr Lothian's decision to commit suicide appears to have resulted both from his predicament, in which he quickly realised he could not escape, and the ready availability of the means to suicide.

Issue 2 – the adequacy of medical treatment and monitoring

2.a. Whether the initial response to Mr Lothian's disclosure of thoughts of self-harm and suicide of 18 December 2020 was adequate (namely, his placement in the Clinic on RIT between 18 and 20 December 2020, before being returned to the Pod).

98. On 18 December 2020, Mr Lothian advised correctional centre staff he was 'feeling down' and had thoughts of self-harm and suicide, and this resulted in the making of a mandatory notification. An Immediate Support Plan dated 18 December 2020 recorded that Mr Lothian should be required to wear 'Full RIT attire' and should be subject to constant electronic observations.[107] He was then transferred to the South Coast CC's Clinic.[108]
99. On 19 December 2020, Mr Lothian was reviewed by RIT staff, and on 20 December 2020 an Outlaw Motorcycle Gang Validation Interview was conducted with Mr Lothian. During the interview, Mr Lothian reported that he had never been a member of, nor associated with, the Hells Angels Outlaw Motorcycle Gang, despite his report to the contrary the day before. Mr Lothian was then advised that as he had no issues, there was no reason he could not return to the Pod. Mr Lothian reportedly said he was fine with that outcome and had no issues.
100. Later on 20 December 2020, Mr Lothian was again reviewed by RIT staff. He reported that he had no thoughts of self-harm and was willing to return to the C-Pod, and he was discharged from the clinic that afternoon.
101. In his second report,[109] Dr Nielssen opines that the decision to refer Mr Lothian for observation and assessment by a risk intervention team was adequate and appropriate, although the consequences for Mr Lothian was that he was detained in an observation cell for three days, and then on a medical hold in the clinic area with only a short time out of one of the cells in that area, which might itself have been counter therapeutic He explained in his oral evidence that the conditions under which an inmate is held when on a RIT are not therapeutic.

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[107] V4/99 – CSNSW Case Management File, pgs 9-10.
[108] V4/100 – CSNSW Case Note Reports, pg 2.
[109] V3/93B.

102. As to the RIT's management of Mr Lothian between 18 and 20 December, Dr Nielssen reports that Mr Lothian was reviewed each day by a three-person risk intervention team and was asked about thoughts of self-harm and was able to provide members of that team with assurances regarding his personal safety.

103. On this issue, Senior Counsel Assisting submitted that Mr Lothian's management by the RIT between 18 and 20 December had achieved its purpose. Ms Stevens, on behalf of CSNSW, and Mr Harris, on behalf of Justice Health, submitted that I would find that Mr Lothian's treatment for mental health was adequate and appropriate during the period 18 to 20 December.

104. I find that the initial response to Mr Lothian's disclosure of thoughts of self-harm and suicide of 18 December 2020 was adequate (namely, his placement in the Clinic on RIT between 18 and 20 December 2020, before being returned to the Pod).

2.b. Whether the referral to Psychology and subsequent attendances by Psychology on Mr Lothian on 30 December 2020 and 4 January 2021 were adequate.

105. On 21 December 2020, Mr Lothian was placed on the waitlist for 'Psych 2 Sub-Acute Suicide / Self Harm' and a Risk Intervention Team review was conducted, following which Mr Lothian was 'stepped down to Greens' with nil issues raised.[110] The form of the referral referring Mr Lothian to CSNSW Psychology was not in evidence, however it seems that the referral to CSNSW Psychology was precipitated by Mr Lothian's disclosure of suicidal thoughts on 18 December 2020.

106. On 30 December 2020, Mr Lothian was assessed by Corrective Services NSW Senior Psychologist Amy Sowerby in response to the 'Psych 2 Sub-Acute Suicide / Self Harm referral' made on his behalf on 20 December 2020.[111] Her Case Note entry for 20 December 2020 records that Mr Lothian was referred due to being recently placed on RIT and concerns for his mental health. The Case Note further records the following:[112]

> Summary:
> The author attended Mathew's clinic cell with a custodial officer. Upon the author introducing herself, her role and purpose of contact, Mathew provided verbal consent to come out and speak to the author. At the commencement of session, the author discussed the Psychology Participant Information statement and the process of consent, including limits to confidentiality, record keeping, and voluntary nature of service. Mathew asked the author whether he had to sign the consent form, the author advised singing [sic] consent is a requirement to speak to a psychologist within CSNSW. Mathew was observed to become slightly restless and agitated, he elected to read the Psychology Participant Information

[110] V4/100 – CSNSW Case Note Reports, pgs 2-3.
[111] Statement of Amy Sowerby dated 14 June 2024, [12].
[112] V4/100 – CSNSW Case Note Reports, pg 5.

Statement again on his own to review information contained in the form. He stated he would like assistance for mental health, however shared experiencing anxiety and hesitations regarding psychology consent parameters and needing to sign the consent form; he shared significant struggles trusting others given his historical experiences. The author attempted to address Mathew's concerns, and reiterated some factors within the consent form (e.g. he is free to withdraw consent at any time, only sharing information which he feels comfortable sharing); however Mathew stated he is still unsure whether he wishes to engage. Mathew agreed to take a copy of the Psychology Participant Information statement and Consent Form 2A back to his cell to review, the author stated she would return next week to discuss further.

Risk:

Nil risk issues identified at time of interview. Mathew denied any current thoughts or risk of self-harm, he stated he will be able to cope until next session. He stated he is coping okay in his clinic cell and feels safe in there. The author advised Mathew to speak to officers if his risk of self-harm should change, or if he requires support before the author returns; he stated willingness to do this if required.

107. Between 31 December 2020 and 3 January 2021, Mr Lothian was regularly monitored by Justice Health staff in the Clinic. The Justice Health file notes for those dates generally record that Mr Lothian did not voice any concerns.[113]

108. On 4 January 2021, Ms Sowerby again saw Mr Lothian. The Case Note records the following:[114]

Presentation:

MSE [Mental State Examination] limited due to brief interaction from cell door and refusal to engage. Appropriately dressed in inmate greens, appeared to be maintaining appearance. Author observed bruises around eyes and bandaged nose from previous session have remained. Appeared agitated, pacing in cell, noted to be staring at author during interaction, remained polite. Mood appeared slightly anxious. Nil issues with speech observed, responses relevant/appropriate to questions asked, very brief responses. Nil indicators of perceptual disturbance observed during interaction.

Summary:

The author attended the clinic in attempt to follow up previous session with Mathew and attain consent. The author attended the cell door with the clinic officer. Mathew declined to come out of his cell. He verbally declined to speak to psychology, and stated he does not wish to engage with psychology services at any time. The author asked whether Mathew would like the author to return at a later time, to which he declined ("no thank you"). The author enquired how he is going in his cell, he stated he is ok. Mathew again confirmed

[113] V6/115 – Justice Health Records, Mathew Lothian, p 401-406.
[114] V4/100 – CSNSW Case Note Reports, p 7.

he does not wish to see psychology, and returned to his bed. He did not sign Form 2C Decline/Withdrawn Consent.

Plan:

- Given inmate is on a PSYCH2 Sub-Acute Suicide/Self-Harm service line, referral remain open to re-attempt contact at a later date.
- Inmate can be re-referred to psychology if required.

109. The referral to CSNSW Psychology Services appears to have been triaged within 3 days and Ms Sowerby arranged to see Mr Lothian nine days after the referral was triaged – that is, well within the 12-week timeframe for "Psych2 Sub-acute Suicide / Self-Harm" referrals. Further, following Mr Lothian's refusal to sign the Form 2A Psychology Participant Information Sheet and Consent Form on 30 January 2020, Ms Sowerby arranged a follow up attendance on him within a relatively short timeframe, five days later on 4 January 2021, noting that this period was during the Christmas and New Year holiday period.

110. On this issue, Senior Counsel Assisting submitted that for Ms Sowerby's attendances on Mr Lothian on 30 December 2020 and 4 January 2021, they appear to have been broadly compliant with CSNSW Psychology Services' policies and practice guides[115]. In this sense, they could be considered "adequate".

111. I agree with the submission of Senior Counsel Assisting that Ms Sowerby's attendances on Mr Lothian on 30 December 2020 and 4 January 2021 were adequate.

112. There is a separate question whether Ms Sowerby's actions in respect of Mr Lothian following her interaction with him on 30 January 2024 were "adequate" in circumstances where Mr Lothian expressed a desire for assistance with his mental health but was unwilling to sign the Form 2A Psychology Participant Information Sheet and Consent Form.

113. Ms Sowerby's evidence was that she interviewed Mr Lothian on 30 December 2020. At the start of the interview, she discussed the Form 2A Psychology Participant Information Sheet and Consent Form with him and the process of consent, including limits to confidentiality. In her OIMS case note of the interview, Ms Sowerby recorded that Mr Lothian asked whether he had to sign the consent form and she advised that signing the consent form is a requirement to speak to a psychologist within CSNSW. She then recorded:[116]

> Mathew was observed to become slightly restless and agitated, he elected to read the Psychology Participant Information statement again on his own to review information contained in the form. He stated he would like assistance for mental health, however shared experiencing anxiety and hesitations regarding psychology consent parameters

[115] See, generally, Annexures B and C of Tab 116.
[116] V7/116 – statement of Amy Sowerby 14 June 2024, Annexure D, p 5.

and needing to sign the consent form; he shared significant struggles trusting others given his historical experiences

114. Ms Sowerby recorded that she attempted to address Mr Lothian's concerns and reiterated some factors within the consent form. However, Mr Lothian was still unsure whether he wished to engage on that basis and agreed to take a copy of the form back to his cell to review prior to a further interview with Ms Sowerby the following week.[117]

115. When Ms Sowerby went to speak to Mr Lothian the following week on 4 January 2021, he refused to exit his cell to speak to her and otherwise refused to engage. In her OIMS case note of this interaction, Ms Sowerby recorded that Mr Lothian appeared agitated, was pacing in his cell, and appeared slightly anxious.[118] Ms Sowerby noted that she asked Mr Lothian whether he would like her to return at a later time, which he declined, confirming that he did not wish to see CSNSW Psychology Services. The "plan" recorded by Ms Sowerby in her OIMS case note of the interaction was to keep the referral open to re-attempt contact at a later date.

116. In oral evidence, Ms Sowerby said that it was common for inmates to express concerns about the Form 2A and the limits to confidentiality and that she had experienced other instances where inmates declined to engage in psychology services because of those limitations.[119]

117. As to her plan in respect of Mr Lothian following the interaction of 4 January 2021, Ms Sowerby confirmed that the referral would remain open for 90 days for CSNSW Psychology Services to re-attempt contact.[120]

118. Ms Sowerby was asked whether, in circumstances where Mr Lothian had indicated that he wanted help for his mental health but did not want to sign the CSNSW Psychology Services Form 2A, he could have been referred to Justice Health for assistance. She agreed that Mr Lothian could have been referred to Justice Health and said that she could not recall whether she had made that suggestion. Ms Sowerby posited that she may have not done so because when she saw Mr Lothian, he was already in the clinic and being seen by Justice Health staff each day.

119. Senior Counsel Assisting submitted that given the detail provided in her notes, it is reasonable to conclude that if Ms Sowerby had made such a suggestion, she would have recorded it in her case note and it may further be concluded that the absence of any reference to having done so suggests she did not. Senior Counsel Assisting noted however that Ms Sowerby gave evidence that she may not have referred Mr Lothian to Justice Health because he was already in the clinic. Ultimately, Senior Counsel Assisting submitted that while Ms

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[117] Ibid.
[118] Ibid, p 7.
[119] Transcript p 63 – 64.
[120] Transcript p 82.

Sowerby's attendances with Mr Lothian on 30 December 2020 and 4 January 2021 complied with CSNSW Psychology Services' policy and procedures, Mr Lothian's expressed desire for assistance with his mental health remained unaddressed and the opportunity of it being addressed as a result of a referral by CSNSW psychology to Justice Health was unfortunately missed.

120. CSNSW submits that there is no reasonable basis for any criticism of Ms Sowerby in this regard as Mr Lothian was housed in the Justice Health clinic at the relevant time and subjected to daily welfare checks (irrespective of whether he was in the clinic for his physical or his mental health). CSNSW submits that it was reasonable for Ms Sowerby to assume that Justice Health staff were engaging with Mr Lothian, that it is apparent from the clinical records that they were in fact engaging with him and that if Mr Lothian sought the assistance of a mental health nurse, one would have been available. CSNSW further submits that the evidence of Dr Bianca Spaccavento, Principal Psychologist with CSNSW, supports its contention that Ms Sowerby's approach was reasonable and appropriate (and adequate).

121. I find that on balance Ms Sowerby did not refer Mr Lothian to Justice Health. I accept that Ms Sowerby may have considered that referring Mr Lothian to Justice was unnecessary as at the time Mr Lothian was in the Justice Health clinic and had daily contact with Justice Health staff. I note the protective factors offered by Mr Lothian's presence in the Justice Health clinic and his daily contact with Justice Health staff, however I agree with the submission of Senior Counsel assisting that Mr Lothian's expressed desire for assistance with his mental health remained unaddressed. In my view, the better course in circumstances such as these, namely where an inmate who reports "feeling down" and has thoughts of suicide and will not consent to treatment from CSNSW Psychology is for CSNSW Psychology to refer the inmate to Justice Health.

2.c. Whether any feature(s) of the "Form 2A: Psychology Participant Information" Mr Lothian was told on 30 December 2020 he was required to sign in order to speak with a psychologist within Corrective Services NSW (CSNSW) may have presented a barrier to him seeking and receiving assistance for the mental health issues he was experiencing.

122. As has already been referred to in these findings, when Ms Sowerby attended Mr Lothian on 30 December 2020, she provided him with Form 2A: Psychology Participant Information and Consent Form (**Form 2A**) and on 4 January 2021, when Ms Sowerby followed up with Mr Lothian, he refused to sign the form. The effect of Mr Lothian's refusal to sign Form 2A was that he did not receive any treatment from CSNSW Psychology, however the referral would remain open for 90 days for CSNSW Psychology to re-attempt contact.

123. Form 2A was in evidence.[121] It is a five-page document which features two parts. The first part, which is the first four pages is titled “Form 2A: Psychology Participant Information” and provides an inmate with information including what CSNSW psychologists do, what any information the inmate provides the psychologist might be used for, and whether any such information will be confidential. As to whether the information the inmate provides the psychologist will be confidential, the form says this:

> The information you give the psychologist has limited confidentiality. The information you give a psychologist is written down in the psychology file. It can be read by Corrective Services Psychologists. Your information may be written down in ‘case notes’ which can be read by staff in Corrective Services. The Commissioner of Corrective Services and the Executive staff may access any Corrective Services files.
>
> The psychologist may also have to discuss your case:
>
> • in general terms, with other staff to help your case management;
>
> • in supervision with other psychologists. Sometimes the supervisor or a training psychologist will ask to sit in with the psychologist during individual or group time;
>
> • if you say you want to hurt yourself or someone else;
>
> • if you give information about a risk to a child or young person;
>
> • if you talk about an offence the police don’t know about;
>
> • if you give information concerning the safety, security and / or good order and discipline of a correctional centre, placement, classification and / or security rating;
>
> • if certain agencies and services, that may include: the Police, the Mental Health Review Tribunal, FACS, the State Parole Authority, the Serious Offender Review Council, NSW Health or the Courts, make formal and legal requests for the information / a report.
>
> All information that a CSNSW psychologist gets is the property of CSNSW and becomes part of the state record, being kept and used forever.

124. The second part of Form 2A comprises one page, titled “Form 2A: Psychology Participant Information Statement and Consent”. On this page the inmate provides his or her confirmation that they have read the Psychology Participant Information Statement, and, “based on this information”, the inmate agrees to see a psychologist. By signing the page, the inmate states that her or she understands that:

> • Participating in psychological contact such as talking to the psychologist or doing assessments is voluntary. I am free to withdraw my consent at any time.
>
> • The information I give the psychologist has limited confidentiality. It is shared within CSNSW and information about me could be subpoenaed by the Police, the Department of Family and Community Services (FACS), the court, or other legal agencies and/or can be accessed by the CSNSW Commissioner.

[121] V8/138.

• A psychological report may be written about me without my consent for agencies with the power to request such a report (e.g. the State Parole Authority, Mental Health Review Tribunal or other agencies).

• My information may be de-identified (made anonymous) and used in research about people who are involved in the criminal justice system.

125. Ms Sowerby's evidence was that she interviewed Mr Lothian on 30 January 2024. At the start of the interview, she discussed the Form 2A Psychology Participant Information Sheet and Consent Form with him and the process of consent, including limits to confidentiality. In her OIMS case note of the interview, Ms Sowerby recorded that Mr Lothian asked whether he had to sign the consent form and she advised that signing the consent form is a requirement to speak to a psychologist within CSNSW. She then recorded:[122]

> Mathew was observed to become slightly restless and agitated, he elected to read the Psychology Participant Information statement again on his own to review information contained in the form. He stated he would like assistance for mental health, however shared experiencing anxiety and hesitations regarding psychology consent parameters and needing to sign the consent form; he shared significant struggles trusting others given his historical experiences

126. Ms Sowerby recorded that she attempted to address Mr Lothian's concerns and reiterated some factors within the consent form. However, Mr Lothian was still unsure whether he wished to engage on that basis and agreed to take a copy of the form back to his cell to review prior to a further interview with Ms Sowerby the following week.[123]

127. In oral evidence, Ms Sowerby said that it was common for inmates to express concerns about the Form 2A and the limits to confidentiality and that she had experienced other instances where inmates declined to engage in psychology services because of those limitations.[124]

128. Dr Spaccavento accepted in her oral evidence it would be quite reasonable for an inmate to be reluctant to engage in counselling with a CSNSW Psychologist out of a concern about the limits of the confidentiality. Dr Spaccavento explained that CSNSW Psychology Services has two principal clients and the inherent difficulty in balancing the needs of those two clients is part of the foundational nature of correctional psychology practice. She further explained that it is CSNSW Psychology Services' policy that the Form 2A must be signed by the inmate for any contact with a CSNSW psychologist.[125]

129. Dr Nielssen gave evidence regarding the Form 2A. In his second report, Dr Nielssen opines that the Form 2A is "written in plain English, but is three pages long, which might be

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[122] V7/116 – statement of Amy Sowerby 14 June 2024, Annexure D, p 5.
[123] Ibid.
[124] Transcript p 63 – 64.
[125] Transcript p 92.

a bit much for a person like Mr Lothian, who only completed one year of high school". He considers that requiring the signing of a consent form might itself intrude on forming a therapeutic alliance and increase suspicion in people who are already untrusting of authority figures. He concludes that the Form 2A could be dispensed with in favour of verbal consent being recorded in case notes.[126]

130. In oral evidence, Dr Nielssen said the Form 2A is much more elaborate than anything he has seen in a health setting and is counter intuitive / counter therapeutic. He expanded that the main circumstances in which he required written consent was for specific therapeutic treatments involving a physical aspect (for example, electroconvulsive therapy) or for information sharing with another agency.[127]

131. Upon being explained the limitations to confidentiality between CSNSW Psychology Services and inmates, Dr Nielssen commented that he accepted that it is reasonable in those circumstances to obtain consent, but that "presenting someone with a three page form before you can even ask them if they are okay is a little bit counter therapeutic".[128]

132. Senior Counsel Assisting submitted that the Form 2A presented a barrier to Mr Lothian seeking and receiving assistance for the mental health issues he was experiencing. He submitted that the problem derives not so much from the Form 2A but from the nature of the forensic psychological service provided by CSNSW Psychology Services and the fact that therapeutic psychological services are not available to inmates in circumstances where patient confidentiality can be maintained. The effect of this it is submitted appears to be that inmates cannot access therapeutic psychological services in circumstances where they request assistance for mental health issues but are unwilling to consent to the service provided by CSNSW Psychology Services taking into account the limited confidentiality of that service.

133. Senior Counsel Assisting further submitted that Dr Spaccavento's evidence was that the capacity of CSNSW Psychologists to provide individual counselling to inmates was also dependent upon their availability at the particular correctional centre and the competing demands on their time, such as the need to do assessments, which would generally take priority.

134. Ms Stevens, on behalf of CSNSW, submitted that the Form 2A and the need for written consent is appropriate in the circumstances and is a necessary part of the ethical provision of psychological services to inmates in custody. The form reflects, it is submitted, the ethical considerations for the multiple relationships (that is, between CSNSW, the psychologist and the inmate); the limitations on confidentiality; and the need to explain such complex information to inmates with limited literacy and education. Ms Stevens further

[126] V4/93B, p 4.
[127] Transcript p 133-4.
[128] Transcript p 140.

submitted that there was no dispute in the evidence on this issue; Dr Nielssen accepted that it is quite reasonable for a practitioner to obtain written consent when necessarily sharing information with another agency such as in a custodial environment.

135. I find that the Form 2A did present a barrier to Mr Lothian seeking and receiving assistance for the mental health issues he was experiencing. It is reasonable that there needs to be consent given by an inmate in the circumstances, however, the extent of the consent that Mr Lothian was asked to provide was a barrier to him agreeing to enter into a therapeutic relationship with CSNSW Psychology. As I have already said in these findings, in circumstances where an inmate is identified as in need of assistance and refuses to sign the Form 2A and therefore refuses to consent to receive treatment from CSNSW Psychology, the better course is for the inmate to then be referred by CSNSW Psychology to Justice Health.

Issue 2.d. Whether an adequate risk assessment was undertaken before Mr Lothian was medically escorted on 6 January 2021 considering his mental health concerns.

136. Dr Nielssen gave oral evidence as to the adequacy of the risk assessment undertaken prior to Mr Lothian's medical escort in light of his mental health concerns. He opined that there was no information to suggest that Mr Lothian posed a particular risk on 6 January 2021 (making this comment with the disclaimer "without getting into a long tirade about risk assessment in general").[129] He expanded by saying there was evidence of his depressed mental state on 6 January 2021 (including his initial refusal to attend the medical escort and sitting with his face in his hands during the drive to Wollongong), but there was no indication that he might attempt suicide.[130] Dr Nielssen considered more generally that Mr Lothian was an impulsive person who made an impulsive decision to commit suicide in light of his predicament (in which he quickly realised he could not escape) and the ready availability of the means to suicide.[131]

137. I find that there was no particular information in relation to any particular risk Mr Lothian posed to be taken on medical escort on 6 January 2021.

Recommendation – Issue 2

138. Senior Counsel Assisting proposed that I make the following recommendation to the Justice Health and Forensic Medicine Network and the Commissioner of Corrective Services NSW:

[129] Transcript p 138-9.
[130] Transcript p 138.
[131] V4/93A – Report of Dr Olav Nielssen dated 22 April 2023, p 10.

Justice Health NSW and Corrective Services NSW consider the benefits of therapeutic psychological services being provided by Justice Health NSW, including how such services would be funded.

139. In support of the proposed recommendation, Senior Counsel Assisting submitted that the evidence before me was that Justice Health may have been able to provide Mr Lothian with assistance for his mental health issues and that assistance might have included being seen by a Justice Health mental health nurse or a Justice Health GP. Given the lack of psychologists within Justice Health however, it is submitted that it is unlikely that Mr Lothian would have received psychological counselling through Justice Health. Senior Counsel Assisting posits that this raises the issue of whether inmates such as Mr Lothian might be better served by the availability of psychological services provided through the auspices of Justice Health, which would likely by subject to greater confidentiality as an alternative, at least where the inmate is reluctant or unwilling to provide the written consent required by CSNSW psychology before they will provide any psychological services.

140. Senior Counsel Assisting further submitted that the Form 2A presented a barrier to Mr Lothian seeking and receiving assistance for the mental health issues he was experiencing. However, the problem derives not so much from the Form 2A but from the nature of the forensic psychological service provided by CSNSW Psychology Services and the fact that therapeutic psychological services are not available to inmates in circumstances where patient confidentiality can be maintained. The effect of this appears to be that inmates cannot access therapeutic psychological services in circumstances where they request assistance for mental health issues but are unwilling to consent to the service provided by CSNSW Psychology Services taking into account the limited confidentiality of that service. Moreover, Senior Counsel Assisting submitted that, as Ms Spaccavento explained, the capacity of CSNSW Psychologists to provide individual counselling to inmates is dependent upon their availability at the particular correctional centre and the competing demands on their time, such as the need to do assessments and alike, which would generally take priority.

141. Mr Harris, on behalf of Justice Health, submitted that Justice Health supports this proposed recommendation. Mr Harris conceded that it is unclear what therapeutic psychological services provided by Justice Health would look like, however, in his submission, critically, Justice Health psychologists would not need to serve two clients, that is, the inmate and the Commissioner. Mr Harris also referred to the competing demands that Corrective Psychologists face.

142. Mr Harris submitted that, ultimately, it is worthwhile considering therapeutic psychological services being provided by Justice Health, and that any consideration of that proposition must include CSNSW as CSNSW already provide psychological services to inmates, so there will need to be engagement between the two agencies. Mr Harris

suggested that the role of Justice Health psychologists would be limited to therapeutic psychology, and not matters such as case management of inmates, and that funding must be explicitly considered as without funding the idea will not go very far.

143. CSNSW does not support this proposed recommendation.

144. On behalf of CSNSW, Ms Stevens respectfully submitted that there was no missed opportunity for the provision of mental health support to Mr Lothian and therefore the proposed recommendation is not necessary. Ms Stevens noted that Mr Lothian was in the Justice Health clinic at the time he reported difficulties with his mental health, and he was subject to daily welfare checks. Further, the evidence suggests that Justice Health staff were aware of Mr Lothian's mental health concerns. Accordingly, Mr Lothian had access to mental health services in addition to those provided by CSNSW Psychology.

145. Further, Ms Stevens submitted that there is insufficient evidence in this inquest on the complexities of the provision of psychological services to inmates in a custodial environment (by either Justice Health or CSNSW or both). Ms Stevens highlighted that I did not receive into evidence any Justice Health policies regarding mental health support to inmates, nor did I hear from any Justice Health witnesses on the issue, or the provision of mental health support at the SCCC, nor is there sufficient evidence on the consent parameters that would be involved in therapeutic psychological services provided by Justice Health.

146. Having closely considered the evidence and submissions, I propose to make the recommendation. I accept the submission of Senior Counsel Assisting that it appears that inmates cannot access therapeutic psychological services in circumstances where they request assistance for mental health issues but are unwilling to consent to the service provided by CSNSW Psychology Services, considering the limited confidentiality of that service.

147. I note the submission made by Ms Stevens that there is insufficient evidence in this inquest on the complexities of the provision of psychological services to inmates in a custodial environment. I accept that submission. I am satisfied however that this matter has identified a gap, at a broad level, in the therapeutic psychological services available to inmates when inmates are unwilling to consent to the terms of treatment offered by CSNSW Psychology. Accordingly, consistent with the recommendation, I think that this issue should be given careful consideration by CSNSW and Justice Health.

148. I make the following recommendation pursuant to s 82 of the Act:

> Justice Health NSW and Corrective Services NSW consider the benefits of therapeutic psychological services being provided by Justice Health NSW, including how such services would be funded.

Issue 3 – the adequacy of the medical escort on 6 January 2021

Issue 3.a. Whether a risk assessment should have been undertaken before Mr Lothian was medically escorted on 6 January 2021, having regard to Custodial Operations Policy and Procedure (COPP) 19.6 (Medical Escorts) and COPP 19.1 (General Escort Procedures).

149. CSNSW policy and procedure provides that a risk assessment should be undertaken before a medical escort is conducted. Clause 1.5 of COPP 19.6 (Medical Escorts) provides that, [132]

150. Jose Noronha is a Senior Correctional Officer at SCCC. On 30 December 2020, he was acting in a higher capacity as Functional Manager of Security. His duties in that role included preparing the Section 24(1) – Transfer to hospital or other place specified order for Mr Lothian's medical escort on 6 January 2021.

151. Mr Noronha's oral evidence is that he conducted a risk assessment in completing the Section 24(1) form. He said that in completing the form, it is necessary to access OIMS and have regard to information including the inmate's classification, associations and any alerts. His evidence was that in reviewing the information about Mr Lothian contained in OIMS, he formed the view that Mr Lothian had a history of erratic behaviour which increased his risk. He formed this view in part due to Mr Lothian's placement on a RIT and refusal to speak to CSNSW Psychology Services on 30 December 2020. He also had regard to the fact that Mr Lothian had recently received injuries, likely because of an assault. He considered these matters increased the risk Mr Lothian might attempt to escape.[133]

152. Mr Noronha's evidence is that he also necessarily had regard to the location of the transfer, in this instance being the Piccadilly Centre in Wollongong. He said he made note of his risk assessment regarding the location of the transfer in the Part 3. Summary section of the form by inserting the comment "Note: Environment in public place/ street". He explained that he made this note as the transfer was to an open environment rather than a hospital, which is an enclosed area and is the more standard location of medical escorts.[134]

153. Mr Noronha said that in light of his assessment of matters which increased risk (namely, Mr Lothian's history of erratic behaviour and the location of the medical escort), he determined that a restraining belt was necessary for the transfer.[135] His evidence was that he recorded this determination in the Part 3 Summary section of the form in the section

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[132] V5/107 – COPP 19.6, [1.5].

[133] Transcript p 265-9

[134] Transcript p 271-2

[135] Transcript p 273

"Authorised instrument of restraint: Handcuffs, Anklecuffs, retraining [sic] belt, 1 x Fire arm".[136]

154. Ms Amanda Buck approved and signed the Section 24(1) Form on 30 December 2020 as the Acting Manager of Security. Her evidence was that she also conducted a risk assessment prior to signing the form, which included speaking to SCCC Clinic staff about Mr Lothian's behaviour. She said that she did not consider it necessary to make any amendments to the Section 24(1) Form as completed by Mr Noronha prior to approving it.[137]

155. Senior Counsel Assisting submitted that while the evidence is that a risk assessment was completed, the issue appears to be the way in which that risk assessment was communicated to the officers conducting the escort – CSO Harvey and SCO Greer – including how the information on the Section 24(1) Form was presented and failure to conduct a pre-escort briefing. I agree with this submission, and I will address this further below.

156. I find that pursuant to clause 1.5 of COPP 19.6 (Medical Escorts) a risk assessment was required and was carried out before Mr Lothian was medically escorted on 6 January 2021.

Issue 3.b. The reasons, if any, the Manager of Security did not conduct a pre-escort briefing with CSO Harvey and CSO Greer on 6 January 2021 as required by COPP 19.6 (Medical Escorts) at [2.1]

157. A pre-escort briefing was not conducted with CSO Harvey and CSO Greer on 6 January 2021 as required by COPP 19.6 (Medical Escorts) at [2.1].

158. CSO Harvey's evidence was that in her relatively limited experience of conducting medical escorts at SCCC and at other correctional centres including Long Bay CC, Mid-North Coast CC and Hunter CC, she had never engaged in a pre-escort briefing with the Manager of Security or their delegate, had never seen anyone receive a pre-escort briefing and had not at any time been informed that she should be engaged in a pre-escort briefing prior to conducting a medical escort. She did not recall having read COPP 19.6 (Medical Escorts) prior to the medical escort of 6 January 2021 and essentially said that she received brief training in medical escorts at Brush Farm Academy and otherwise learnt "on the job".[138]

159. CSO Greer's evidence was that he had more extensive experience of conducting medical escorts. This experience primarily derived from a period between 2010-2011 where he worked within the Medical Escort Unit at Long Bay Hospital and conducted 3-4 medical escorts daily. It was also informed by medical escorts conducted at several other correctional centres, including SCCC.[139]

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[136] V2/18 – Statement of Jose Noronha dated 23 July 2021, [5].
[137] Transcript p 299; V2/22 – Statement of Amanda Buck dated 19 March 2021, [5]-[8].
[138] Transcript p 147, 168-71.
[139] Transcript p 215, 222.

160. CSO Greer said that in his experience, pre-escort briefings were not conducted as a matter of course prior to medical escorts. He said that when he worked in the Medical Escort Unit at Long Bay Hospital, he would often receive an informal briefing from the "Deps Clerk" who worked in the Medical Escort Office and it seems was a delegate of the Manager of Security. He said that you would "sometimes" receive a pre-escort briefing upon collecting the equipment required for the escort in that the "Deps Clerk" would advise if there was anything to be mindful of or any concerns. This was not something that was done all the time; only if the "Deps Clerk" wanted to pass certain information along. As to a briefing with the Manager of Security, CSO Greer said that he would sometimes speak to the Manager of Security prior to an escort. He explained that this would arise in circumstances where officers "had the time" and so would "go say hello and ask if there's anything we need to know". He explained that in these circumstances, the extent of the briefing was asking if there was anything they needed to know, occasionally with reference to the Section 24(1) Form.[140]

161. Like CSO Harvey, CSO Greer's evidence was that he received some training regarding medical escorts at Brush Farm Academy and otherwise learnt on the job through being paired with a more experienced officer. He could not recall having previously read COPP 19.6 (Medical Escorts) at [2.1] but assumed that he would have read it at some stage.[141]

162. Senior Correctional Officer Jose Noronha was on leave on 6 January 2021. His evidence was that the responsibility to conduct a pre-escort briefing prior to a medical escort fell to the Functional Manager of Security on duty on the day of the escort. He said this was the appropriate course in circumstances where changes to the assessment of risk could occur between the date the form was completed and the date of the escort.[142]

163. Ms Amanda Buck was the A/Manager of Security on 6 January 2021. In her experience pre-escort briefings are not ordinarily conducted. Specifically, she said that she had, on occasion, conducted pre-escort briefings for certain escorts in circumstances where she had identified safety and security issues and wanted to reiterate those issues to the Correctional Service Officers conducting the escort. She said that beyond this, the onus is on Correctional Service Officers to proactively seek out the Functional Manager of Security or Manager of Security if they have any concerns regarding a specific escort.[143]

164. Senior Counsel Assisting submitted that the reasons why a pre-escort briefing was not conducted with CSO Harvey and CSO Greer on 6 January 2021 appears to be because of a failure in understanding the requirement of the COPP and or a culture of non-compliance within CSNSW.

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[140] Transcript p 217-8.
[141] Transcript p 219.
[142] Transcript p 269-70, 284-5.
[143] Transcript p 302-4.

165. I accept the submissions of Senior Counsel Assisting and find that the reasons why a pre-escort briefing was not conducted with CSO Harvey and CSO Greer on 6 January 2021 appears to be because of a failure in understanding the requirement of the COPP and or a culture of non-compliance with such requirements, within CSNSW.

Issue 3.c. Whether a restraining belt ought to have been applied to Mr Lothian for the purposes of the escort, having regard to COPP 19.6 (Medical Escorts) at [2.5].

166. Clause [2.5] of COPP 19.6 relevantly provides that [redacted] Given Mr Lothian was classified as B, use of a restraining belt in his medical escort was [redacted].

167. The Section 24(1) Form for Mr Lothian's medical escort specified the use of, amongst other things, a "retaining [sic] belt" and Mr Noronha, who conducted the risk assessment in respect of Mr Lothian's medical escort when he completed the Section 24(1) Form, gave evidence that he expected the escorting officers use the restraining belt.[144]

168. CSO Harvey, CSO Greer and Ms Buck each indicated that on their understanding of the Section 24(1) Form, the appropriate section on which to record that a restraining belt was required for the purposes of the transfer was in Section 8 "Additional / special considerations" in the "Other (specify)" section of the form. In each of their opinions, the reference to a "retaining [sic] belt" in the "Part 3 Summary" section of the form indicated that a restraining belt had to be taken with them on the medical escort, not that it had to be applied to Mr Lothian.[145]

169. Senior Counsel Assisting submitted that on a plain reading of the form, the location on which Mr Noronha recorded information regarding the restraining belt is confusing, hard to identify and apt to mislead.

170. Mr Russell, on behalf of Mr Noronha and CSO Harvey, submitted that the restraining belt was [redacted] or unambiguously identified in the Section 24 Form as required and that Mr Noronha conceded that he could have made the requirement to use the restraining belt clearer in the Section 24 Form.

171. CSNSW accepts that there were some deficiencies and ambiguities in the operation of the Section 24 Form and the escort assessment. Ms Stevens, on behalf of CSNSW, referred to the evidence of the General Manager of Security and Custody, Malcom Brown, who acknowledged that the Section 24 form in force at the time of Mr Lothian's death was

[144] V2/18 – statement of Jose Noronha dated 19 March 2021, [6]; transcript p 274-5.
[145] Transcript p 187, 230, 305.

open to misinterpretation. He agreed that the best way to convey information in preparation for an escort is by way of a briefing from a senior officer.[146]

172. Ms Stevens referred me to the updated version of the COPP 19.6 policy (version 1.16) which, it is submitted, been significantly revised since the death of Mr Lothian. Additionally, Ms Stevens highlighted that an Assistant Commissioner's Memorandum was circulated within CSNSW following Mr Lothian's death requiring the Section 24 Form and Escort Assessment to be completed on the day of an escort.[147] An online training course has also been developed on the completion of the Section 24 Form.

173. Ms Stevens submitted that the proposed changes to the Section 24 Form and Escort Assessment include the requirement for a briefing on the security arrangements and that an escort officer must sign the form as a written acknowledgment that such a briefing has been conducted prior to an escort. Ms Stevens further submitted that the CSNSW Security Operations Groups are in the process of development of training resources for new recruits and existing officers on the revised policies.

174. This issue highlights the importance of pre-escort briefings. The briefing would have provided an opportunity for Mr Noronha's expectation that the restraining belt be used to be conveyed to CSO Harvey and Greer in circumstances where, as Senior Counsel Assisting submitted and I accept, that on a plain reading of the form, the location on the form which Mr Noronha recorded information regarding the restraining belt is confusing, hard to identify and apt to mislead.

175. In his written submissions, Mr Russell submitted that the officer in charge of the NSW Police investigation, Detective Sergeant Joerdens, opined that the absence of a restraining belt allowed Mr Lothian greater movement,[148] and therefore Detective Joerdens made a "general recommendation" regarding the use of restraining belts. Mr Russell acknowledged the absence of "appropriate evidence" regarding the utility of restraining belts but nevertheless suggested that there is an inherent risk that inmates will attempt to escape, no matter their classification, and that it does not appear that the use of a restraining belt would be an "unreasonable restriction" on an inmate.

176. Following the receipt of Mr Russell's written submissions, I granted leave to CSNSW to provide short written submissions in reply. CSNSW does not support the recommendation proposed by Mr Russell. Ms Stevens, on behalf of CSNSW, submitted that the recommendation is not consistent with the principle (as found in relevant legislation and in CSNSW policy and procedure) that officers should use the least restrictive practices on inmates during escort. Moreover, Ms Stevens submitted that the CSNSW policy appropriately

[146] Transcript p 323.
[147] Exhibit 6.
[148] V1/8 – statement of Detective Seargeant Jayson Joerdens dated 30 September 2021, [563].

provides that restraining belts must be used on inmates with designated classifications according to risk.

177. I accept the submissions of CSNSW regarding Mr Russell's proposed recommendation and accordingly do not make the recommendation.

Issue 3.d. Whether the actions of CSO Greer and CSO Harvey were appropriate during the medical escort. In particular:

i. Whether CSNSW policies and procedures regarding the use of restraining belts during medical escorts (specifically, COPP 19.6 (Medical Escorts) at [2.5]); and

ii. Whether CSNSW policies and procedures regarding the use and securing of firearms for the purposes of medical escorts (specifically, COPP 19.6 at [2.4])

were followed, noting that Mr Lothian was able to seize CSO Harvey's firearm while hand and ankle cuffed.

178. I have already referred to the fact that the use of a restraining belt [redacted].

179. Clause 2.4 of COPP 19.6 requires, amongst other things, [redacted] and that the armed officer must maintain a safe distance from the inmate during the transfer of the weapon. Relevantly, a "safe distance" while carrying a firearm is specified in cl 299(2) of the *Crimes (Administration of Sentences) Regulation 2014*, which provides that "a correctional officer must not – (a) place himself or herself in a position where he or she is liable to be attacked, or (b) except when outside a correctional centre or where the governor otherwise directs, approach to within reach of an inmate or allow an inmate to approach to within reach of him or her".

180. Senior Counsel Assisting submitted that plainly, CSO Harvey was in a position where she was liable to be attacked by Mr Lothian; she had the van immediately to her right and another vehicle immediately to her left with the barrier at the edge of the car part just behind her. She was hemmed in with little means of egress. Senior Counsel Assisting submitted that that CSO Harvey came to be in such a position is reflective of a lack of training in situational awareness when carrying a firearm on a medical escort.

181. Mr Russell submitted that CSO Harvey and Greer did their best in the circumstances, including their knowledge of Mr Lothian, Mr Lothian's behaviour on 6 January 2021 and the equipment that the Section 24 Form required use of.

182. I accept Mr Russell's submission that CSO Harvey and Greer were doing their best in the circumstances, however, as Senior Counsel Assisting submitted, plainly CSO Harvey was in a position where she was liable to be attacked by Mr Lothian; she was hemmed in with little means of egress at the time that Mr Lothian attacked her and obtained her firearm.

Recommendation – Crimes (Administration of Sentences) Regulation 2014

183. Senior Counsel Assisting proposed that I make the following recommendation to the Commissioner of Corrective Services:

> That there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, cl 299 of the Crimes (Administration of Sentences) Regulation 2014, having regard to the findings in the inquest into the death of Mathew Richard Lothian.

184. Senior Counsel Assisting submitted that over the course of this inquest it was apparent that what is required by cl 299(2)(a) and (b) of the *Crimes (Administration of Sentences) Regulation 2014* is not readily discernible. The wording of it is apt to confuse. Senior Counsel Assisting noted that in the inquest into the death of Dwayne Johnstone, I made a recommendation in terms that there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, cll 131 and 303 of the *Crimes (Administration of Sentences) Regulation 2014* having regard to my findings in that matter. Senior Counsel Assisting submitted that a recommendation in identical terms should be made in this matter, but with a focus on cl 299, with an expectation that a recommendation in those terms would allow for cl 299 to be given appropriate attention in a review of the *Crimes (Administration of Sentences) Regulation 2014* as I recommended in the inquest into the death of Mr Johnstone.

185. CSO's Harvey and Noronha support the proposed recommendation.

186. CSNSW supports the proposed recommendation but suggested that it may be more appropriately directed to the NSW Attorney General and Minister for Corrections. I accept that submission.

187. Having closely considered the evidence and submissions, and noting the recommendation I made in the inquest into the death of Dwayne Johnstone, I make a recommendation in the following terms pursuant to s 82 of the Act:

> To the NSW Attorney General and to the NSW Minister for Corrections, I recommend:
> That there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, cl 299 of the Crimes (Administration of Sentences) Regulation 2014, having regard to the findings in the inquest into the death of Mathew Richard Lothian.

Issue 3.e. Whether CSO Greer and CSO Harvey were familiar with conducting medical escorts and the CSNSW policies and procedures relating to medical escorts.

188. CSO Harvey's evidence was that prior to 6 January 2021 she had conducted 10 medical escorts over the course of her ten-year career.[149] As to CSO Harvey's familiarity CSNSW policies and procedures relating to medical escorts, her evidence was that she had first read COPP 19.6 (Medical Escorts) and cl 299(2) of the *Crimes (Administration of Sentences) Act* three weeks prior to the inquest, as part of her preparation for giving evidence at the inquest. She had no recollection of having seen or receiving training with respect to COPP 19.6 (Medical Escorts) or cl 299(2) prior to that point.[150]

189. As I have already referred to, CSO Greer had relatively extensive experience conducting medical escorts compared with CSO Harvey. As to the CSNSW policies and procedures regarding medical escorts, CSO Greer's evidence was initially that he had "probably" read the policies at some stage. However, upon being taken to COPP 19.6 (Medical Escorts), he advised that he had no recollection of having previously seen or read that policy.[151]

190. I find that CSO Harvey and Greer did have some familiarity conducting medical escorts (CSO Greer more so than CSO Harvey), but they had limited knowledge of the applicable legislation and relevant CSNSW policies, which I will address further below.

Issue 3.f. Whether CSO Greer and CSO Harvey had been adequately trained in the applicable CSNSW policies and procedures relating to medical escorts.

191. I have just addressed CSO Greer and CSO Harvey's experience in relation to medical escorts and their familiarity with relevant CSNSW policy.

192. CSO Harvey said that apart from her initial training at the Brush Farm Academy, she had never had any refresher training in respect of medical escorts.[152] In his evidence, CSO Greer said that he could not recall having completed training specifically in respect of medical escorts since his initial training at the Brush Farm Academy.[153]

193. Senior Counsel Assisting submitted that CSO Harvey and CSO Greer did not receive adequate training in the applicable CSNSW policies and procedures relating to medical escorts. Senior Counsel Assisting acknowledged however there was evidence that in August 2021, the Security Operations Group developed and introduced the Escort Procedure Course covering key aspects of the roles and responsibilities of custodial officers conducting inmate escorts, including medical escorts, and although it is not mandatory, it is targeted to all custodial staff up to and including the rank of Senior Correctional Officer.

194. Ms Stevens, on behalf of CSNSW, also referred me to the introduction of the Escort Procedure Course. Ms Stevens further referred me to the introduction in 2021 of the

[149] Transcript p 145.
[150] Transcript p 163-4
[151] Transcript p 219, 221.
[152] Transcript p 144.
[153] Transcript p 219.

Advanced Escort Procedure Course which is designed for the Medical Escorts Unit and various specialised units within CSNSW. CSNSW referred me to the evidence of the General Manager of the Security Operations Group, Kenneth Pese. Mr Pese's gave evidence that the [redacted].[154]

195. I find that the training provided to CSO Harvey and Greer with regards to medical escorts was not adequate. I acknowledge the steps taken by CSNSW towards improvement in this area.

Issue 3.g. Whether, having regard to the events of 6 January 2021, CSNSW policies and procedures regarding medical escorts are adequate in respect of the identification and assessment of associated risks, the use of restraining belts and the use and securing of firearms.

196. On this issue, Senior Counsel Assisting submitted that it followed from his previous submissions in this inquest that I should find that the CSNSW policies and procedures regarding medical escorts were not adequate in respect of the identification and assessment of associated risks, the use of restraining belts and the use and securing of firearms. Senior Counsel Assisting noted the acknowledgment by CSNSW of the problems with the policies and the regulation and he acknowledged CSNSW's openness to suggestions and ideas for improvements that might be considered as part of its review of escort procedures, particularly in the area of medical escorts. Senior Counsel Assisting submitted that given the whole escort policy is under review, which includes the s 24(1) Order and associated escort risk assessment, he does not submit there is a need for me to make a recommendation, in the expectation that the current review will have regard to these findings.

197. I accept the submissions of Senior Counsel Assisting on this issue, and I note the openness of CSNSW to improve in this area. I further note that since Mr Lothian's death CSNSW is in the process of reviewing the entire escort policy, and there is no need for me to make a recommendation on this issue, in the expectation that the current review will have regard to these findings.

Issue 4 – Whether the firearm and holster issued to CSO Harvey on 6 January 2021 was appropriately assessed as to its condition before being issue to her

Issue 4.a. Whether the holster issued to CSO Harvey on 6 January 2021 had the mechanisms referred to in the document at Tab 113 of the brief entitled "Understanding Holster Retention Methods" and if so, whether CSO Harvey was aware of how to use them.

[154] Transcript p 373-4.

198. Crime Scene Officer Detective Technical Sergeant Corinne Lynch inspected the [redacted] revolver and firearm holster that CSO Harvey was issued on 6 January 2021. Detective Sergeant Lynch gave evidence that the holster had different aspects directed towards retention of the firearm:[155]

a. [redacted]

[redacted]

[redacted]

199. Prior to 6 January 2021, CSO Harvey received [redacted] training during her initial officer training in 2011, and she completed further training in August 2019.[156] In her evidence, CSO Harvey said that she had been given training as to how a holster should work, including how to remove the firearm from the holster and how the front retention panel works.[157] More recently, in 2023 and 2024, CSO Harvey completed an online annual firearms refresher course in relation to the [redacted].[158]

200. I find that CSO Harvey was aware of how the holster issued to her retained the firearm.

Issue 4.b. Whether the holster was in a proper condition for use by a Correctional Officer conducting a medical escort, noting the expert opinion of Detective Technical Sergeant Lynch

201. Detective Sergeant Lynch gave evidence that the combination of the particular revolver and the holster was such that the effectiveness of each of the three features of weapon retention provided by the holster was adversely impacted.

202. [redacted]

[redacted]

[redacted]

[155] Transcript, p 43-4.
[156] V2/21 – statement of Glen Phillips, p 57; Exhibit 4, p 1.
[157] Transcript p 150-1.
[158] Exhibit 4, p 1.
[159] V3/64 – D/Sgt Lynch 16.07.2021, [46].
[160] V3/64 – D/Sgt Lynch 16.07.2021, [49].

.[161]

205. An additional problem was that the holster was not fixed to CSO Harvey's belt but was able to slide along the belt. Detective Sergeant Lynch's evidence was this would have an impact on the ability of the officer to draw the weapon.[162] Detective Sergeant Lynch observed that the words "Range Kit" has been scratched into the leather of the holster.[163]

206. During Detective Sergeant Lynch's evidence I had the opportunity to handle the firearm and holster issued to CSO Harvey on 6 January 2021 and compare the condition of the holster issued to CSO Harvey with a similar holster provided by NSW Police. I found that it was far easier to remove the firearm from the holster issued to CSO Harvey on 6 January 2021 compared to the similar holster provided by NSW Police.

207. In his evidence, Mr Pese acknowledged the holster featured a lot of wear and tear and that the holster clasp appeared to undo easily. He also pointed out that the holster had been marked as "Range Kit", which indicated to him that the evidence of wear on the holster was from excessive and repetitive use over a long period as part of weapons training. He suggested storing items of range kit separate to operational equipment.[164]

208. I find that the holster issued to CSO Harvey on 6 January 2021 should not have been issued to her. The holster was clearly not fit for operational use, and this was likely caused by repetitive use of the holster as a training aid.

Issue 4.c. Whether CSNSW policies and procedures regarding the inspection of firearms and other security equipment were complied with in respect of the firearm and holster issued to CSO Harvey on 6 January 2021

209. Clause [2.2(2)] of COPP 16.6 (Armoury and Armed Posts) states that .[165] As Senior Counsel Assisting submitted, it may be accepted that a correctional officer who is issued an appointment should satisfy themselves the appointment is in operational condition. However, that presupposes the officer knows what the serviceability criteria for the particular appointment are and how to check those serviceability criteria.

210. The evidence of Mr Pese is that to date, no checklist of serviceability of holsters has been developed.[166] Indeed to date, there has not been any formal process for the inspection of firearm holsters.[167] However, as a result of the evidence at this inquest, Mr Pese has

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[161] V3/64 – D/Sgt Lynch 16.07.2021, [50].
[162] Transcript, p 42-3.
[163] V3/64 - D/Sgt Lynch 16.07.2021, p 211.
[164] Transcript p 355-6, 359
[165] V5/110 – COPP 16.6, [2.2(2)] and see also, V7/118 – statement of Kenneth Pese 11 June 2024, [43]-[44].
[166] Transcript, p 361.
[167] V7/118 - statement of Kenneth Pese 11 June 2024, [45].

started to develop material relating to the inspection of holsters for the to be incorporated in weapons handling training.[168] Additionally, in 2022 CSNSW introduced a mandatory online refresher course and an annual safe handling course for the .[169] Mr Pese gave further evidence that the is to be decommissioned from CSNSW operational use, and replaced by another firearm.[170] New holsters will be introduced with the new firearm, and according to Mr Pese, the new holsters offer better retention of the firearm in the holster.[171]

211. In circumstances where CSNSW have not developed any formal process for the inspection of firearm holsters or a serviceability checklist, it is unclear to me how officers issued with a holster would comply with cl [2.2(2)] of COPP 16.6 (Armoury and Armed Posts) to ensure that the holster is operational at the time of issue. That there is no formal process for the inspection of firearm holsters or a holster serviceability checklist is of concern to me, however I accept that CSNSW are undertaking work to improve this area of operation. I will say more about this in consideration of issue 4.d.

Issue 4.d. Whether CSNSW policies and procedures regarding the inspection of firearms and other security equipment are adequate, having regard to the events of 6 January 2021.

212. Clause [1.3] of COPP 16.6 (Armoury and Armed Posts) requires .[173]

213. Clause [1.2] of COPP 16.14 lists the elements of the daily security reporting system. Several items, including "Weapons" are listed under the sub-heading of "Equipment", however there is no specific reference to holsters.[174] Mr Pese gave evidence that COPP 16.14 does not provide a specific requirement for the holsters to be inspected.[175]

214. Further, the Local Operating Procedure for the Armoury at South Coast CC in force at the time provided for checking arms, ammunition and other equipment. Relevantly, sub-clauses [5.5.1]-[5.5.4], provided as follows:[176]

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[168] Transcript, p 374.
[169] Transcript, p 374-5
[170] Exhibit 7 – statement of Kenneth Pese dated 29 September 2024; transcript p 375-7.
[171] Transcript, p 376.
[172] V5/110 – COPP 16.6, [1.3].
[173] Ibid, [1.4].
[174] V8/127 – COPP 16.14
[175] Transcript, p 366.
[176] V8/137 – LOP SCC SEC 001 v5 dated 20.11.2018, [5.5.1]-[5.5.4].

215. I find that the LOP referred to above required periodic serviceability checks of the firearm holsters held in the armoury. [5.5.2] – [5.5.3] of the LOP ” (emphasis added). In my view, firearm holsters fall into the category of “equipment” that required inspection for serviceability. On a plain reading of the LOP and noting the vital importance of serviceable firearm holsters to the safety of CSNSW officers, inmates and the general public, firearm holsters fall into the category of “equipment” and should have been periodically inspected for serviceability.

216. I issued a Subpoena for Production to CSNSW seeking records relating to any inspection, assessment or modification of the holster issued to CSO Harvey on 6 January 2021 in the period 1 December 2020 to 6 January 2021. By letter, CSNSW stated that no specific records regarding the holster were able to be located.[177]

217. There was no evidence before me that the firearm holster issued to CSO Harvey on 6 January 2021 or any other firearm holsters at SCCC were being physically periodically inspected as required by the LOP. This is perhaps unsurprising in circumstances where CSNSW do not have a formal process for the inspection of firearm holsters or a holster serviceability checklist.

Recommendations – Issue 4

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[177] V8/120 – letter from Claire Dunn dated 17 May 2024.

218. Senior Counsel Assisting proposed that I make the following recommendations to the Commissioner of Corrective Services:

> That Corrective Services NSW urgently develop serviceability criteria for the assessment of whether holsters and associated equipment related to the retention of firearms are in a proper operational condition and develop training for correctional officers in the assessment of the condition of that equipment according to that serviceability criteria.
>
> That an urgent audit be undertaken of all armouries to identify and remove any holsters and associated equipment related to the retention of firearms that may not be in proper operational condition.

219. CSNSW supports that I make both proposed recommendations.

220. Equipment issued to CSNSW officers should be serviceable. That is especially so if the equipment relates to the carriage of a firearm.

221. As I have already referred to, to date no checklist for the serviceability of holsters has been developed, nor has there been any formal process for the inspection of firearm holsters. Consistent with the evidence of Mr Pese, in my view this is an important first step towards ensuring that holsters and associated equipment related to the retention of firearms are in a proper operational condition before being relied upon by CSNSW officers. It also important that CSNSW officers are trained in the assessment of the condition of that equipment according to that serviceability criteria.

222. As to the second proposed recommendation, Senior Counsel Assisting submitted that such a recommendation is necessary having regard to the circumstances of the holster and belt issued to Officer Harvey and the lack of regular inspections of holsters and associated equipment related to the retention of firearms. Senior Counsel Assisting further submitted that although CSNSW is transitioning to a new firearm which will result in the phase out of holsters of the kind issued to Officer Harvey, the transition will understandably take some time and [redacted] [redacted]. Accordingly, there is a need to address the issues relating to the holster identified in this inquest much earlier. I accept these submissions.

223. Having closely considered the evidence and submissions, I make the following recommendations pursuant to s 82 of the Act:

To the Commissioner of Corrective Services NSW:

That Corrective Services NSW urgently develop serviceability criteria for the assessment of whether holsters and associated equipment related to the retention of firearms are in a proper operational condition and develop training for correctional

officers in the assessment of the condition of that equipment according to that serviceability criteria.

That an urgent audit be undertaken of all armouries to identify and remove any holsters and associated equipment related to the retention of firearms that may not be in proper operational condition.

Concluding remarks

224. I would like to offer my sincere sympathy to Mr Lothian's family for the tragic loss of Mathew.

225. I am grateful to the interested parties and their legal representatives for the constructive way in which this inquest was approached.

226. Finally, I thank Senior Counsel Assisting, Mr Ranken SC, Counsel Assisting, Grainne Marsden, and their instructing solicitor, Mr Sampson of the NSW Crown Solicitor's Office, for the thorough and diligent assistance they provided to me during this inquest.

227. I close this inquest.

Magistrate Teresa O'Sullivan
NSW State Coroner