



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of Michael Black

Hearing dates: 17-21 March 2025

Date of findings: 22 August 2025

Place of findings: Coroners Court of NSW, Lidcombe

Findings of: **Magistrate Harriet Grahame, Deputy State Coroner**

Catchwords: CORONIAL LAW – death in custody – Parklea Correctional Centre – stab wound to the chest – use of gaol-made weapon – 18 inmates in holding cell – failure to search inmates – monitoring of CCTV screens – high security and extreme high security designations – decision to revoke segregation direction – waitlist for drug and alcohol assessment – access to opioid substitution therapy in custody

File number: 2020/00121160

Representation: **Counsel Assisting:** Chris McGorey and Hannah Donaldson, instructed by James Prindiville and Camilla Blome of the Crown Solicitor’s Office

Counsel for the Commissioner of Corrective Services NSW: Peter Aitken, instructed by Alexis McShane of the Department of Communities and Justice

Counsel for MTC-Broadspectrum Pty Ltd, Luke Everett, Diane Milner, Shellie Brown, and Mark Hurlstone: Tim Hackett, instructed by Shaun Bailey of Ash Street Partners

Counsel for St Vincent’s Correctional Health: Tracey Stevens, instructed by Seun Idowu of Hall & Wilcox

Counsel for David Palavi: Linda Barnes, instructed by Michael Taylor of Hughes & Taylor Solicitors

Counsel for Tori Welsh and Wise Lagilevu: Anthony Howell, instructed by Michael Burns of McNally Jones Staff Lawyers

Non-publication orders: Non-publication orders made on 19 March 2025 and 22 August 2025.

A copy of the orders can be obtained on application to the Registry of the Coroners Court.

Findings

Identity

The person who died was Michael Black.

Date of death

He died on 22 April 2020.

Place of death

He died at Parklea Correctional Centre, Parklea NSW.

Cause of death

The cause of death was a stab wound to the chest.

Manner of death

Michael was lawfully in custody. He was stabbed by a known person while confined in a crowded cell with numerous other inmates in the Reception Area. Deficiencies in the Parklea Correctional Centre's risk assessment/mitigation practices, search practices, and the management of inmates at the time (e.g. the number of inmates placed in the cell), and the fact that Michael had yet to be assessed for opioid substitution therapy by St Vincent's Correctional Health as he had requested, were contributing factors to what unfolded in the cell immediately before the infliction of the stab wound.

Recommendations

To the Chief Executive of MTC

1. MTC review its procedures, instruction, and training as regards the conduct of Segregation Review Committee reviews and the formal lifting of segregation directions, having regard to the findings in these proceedings. This includes, but is not limited to, the importance of documenting reviews and the factors that were considered in determining whether or not to lift a segregation direction (including the appropriate record keeping and/or file management for that documentation).
2. MTC review its procedures, instruction, and training as regard when an inmate should be considered for referral to the High Security Inmate Management Committee for consideration of designation pursuant to CSNSW Custodial Operations Policy and Procedure 3.5 (e.g., High Security or Extreme High Security), having regard to the findings in these proceedings.

3. MTC review its procedures with a view to expressly stipulating that specific correctional officers or supervisors who are working in the Reception Area in a given shift must expressly monitor the number of inmates placed in holding cells at a given time and to take steps to prevent unsafe numbers in these cells (including providing instruction on what action to take if an officer is concerned about cell numbers), having regard to the findings in these proceedings.
4. MTC urgently review its current limits on the maximum number of inmates that can be safely held in the cells within the Reception Area of Parklea Correctional Centre, having regard to the findings in these proceedings (this extends to potentially seeking advice from a work health and safety expert in this respect).
5. MTC review any training and instruction it provides Immediate Response Team members in responding to a violent encounter within a cell having regard to any lessons that might be drawn from the events on 22 April 2020 and the findings in this matter (separate to that provided externally by the Corrective Services Security Operations Group).

To the Commissioner of Corrective Services and the Chief Executive of MTC

6. CSNSW and MTC review its arrangements concerning the provision of Serious Incident Reports completed by CSNSW into the death of an inmate at an MTC-operated correctional centre to MTC, having regard to the findings made in these proceedings.

TABLE OF CONTENTS

Introduction	6
The role of the coroner and the scope of the inquest	6
The evidence	7
Background and brief chronology	7
Violence in NSW prisons.....	8
Parklea Correctional Centre	8
Management of Emmett Sheard in late 2019/early 2020	9
Emmett Sheard's history	9
Events between August 2019 and April 2020.....	10
Management of inmates that pose a risk of violence	11
Specific risk management measures utilised to manage Mr Sheard's risk of violence post the 24 December 2019 stabbing	13
Practices regarding the SRC as of early 2020	13
Available records regarding the lifting of Mr Sheard's segregation direction.....	15
Matters the SRC/decision-maker may have considered in determining whether to lift the segregation direction	17
Absence of documentation as to the reasons for lifting the segregation direction.....	19
Should the segregation direction have been lifted on 31 January 2020?	19
Events between 1 February and 22 April 2020	25
Escort of AVL inmates to Reception on 22 April 2020	27
Inmates not searched on 22 April 2020.....	27
What happened with the search.....	28
Findings as to the failure to search	29
Changes to searching practice and policy since 22 April 2020	30
AVL inmates within the Reception Area	31
PCC Reception Area on 22 April 2020.....	31
AVL suite.....	31
Decision-making around cell placement and numbers.....	32
Numbers of AVL inmates attending the Reception Area	33
Cell 4's capacity	33
Risks posed by overcrowding.....	34
Findings regarding the numbers in cell 4 on 22 April 2020.....	34
Specification of cell limits	35
What happened at the Reception Holding Area	37
Placement of the AVL inmates in cell 4 at about 9:30am	37
Supervisor Palavi identified Mr Sheard in the cell before the first violent exchange.....	37
Covering of the cell 4 camera at about 11:30am.....	38
Workload in the Reception Area at about 11:30am.....	38
When did the Reception staff realise the camera had been covered?	39
How staff might have responded had the covering of the camera been realised	40
Changes to CCTV monitoring after 22 April 2020	40
Response of COs and the IRT to the violent encounters in cell 4	40
Findings as to what immediately preceded the infliction of the fatal stab wounds.....	42

Adequacy of the response of the COs and the IRT	43
Lack of use of IRT body worn cameras	44
Serious Investigation Report	44
Michael’s access to medical treatment at the PCC.....	45
Michael’s background.....	45
Whether Michael had dependence on opioids at the time he entered the PCC on 28 February 2020	46
Relevance of Michael’s substance use to the events on 22 April 2020	47
Opioid replacement therapy at the PCC.....	47
Initial reception and assessment on reception	47
Referrals for reviews	48
Requests to commence OTP and medical review for other complaints	49
Wait times for assessment for ORT in the community.....	51
Michael’s reports of pain and the potential impacts of cravings on his behaviours	52
Overall.....	53
Findings.....	54
Recommendations.....	54
Conclusion	55

Introduction

1. This inquest concerns the death of Michael Black.
2. Michael was a First Nations man (Palawa) from Tasmania who was 33 years of age at the time of his death.
3. On 22 April 2020, Michael was fatally stabbed at the Parklea Correctional Centre (**PCC**) by another inmate, Emmett Sheard. This incident took place in Reception holding cell 4 where a total of 18 inmates were present.
4. The fatal stab wound entered Michael's chest piercing his right lung.
5. Michael was removed from the cell and emergency treatment was provided to him at the scene by nurses and a doctor from within the PCC. Medical specialists also attended the PCC in a care flight helicopter. Despite their best efforts, Michael was unable to be saved and died at the scene. He was declared life extinct at 12:57pm.
6. Michael is survived by his two children, his mother, his brother, and two sisters. At the time of his death, Michael was in a relationship with the mother of his second child, who was born after Michael died.
7. Members of Michael's family attended the inquest and a family statement prepared by Michael's daughter was read to the Court. She is now 13 years of age and she spoke of her profound loss. She told the Court that "*even though he was in prison... he was still my dad, my hero and my best friend.*" She spoke of the trauma and pain of losing her father and of her broken heart.
8. The family's courage and grace was evident at all times during these proceedings. While they mourned the loss of a precious family member, they remained conscious of how difficult these proceedings were for some of the correctional officers (**COs**) who gave evidence. I thank Michael's brother and mother for their attendance and once again offer them my very sincere condolences for their profound loss.

The role of the coroner and the scope of the inquest

9. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.¹ A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.²
10. For part of his period in custody, Michael was held at a privately operated prison. While there has been an announcement that the prison will return to State management in late 2026, PCC remains privately managed and is now operated by Management & Training Corporation

¹ Coroners Act 2009 (NSW) s 81.

² Coroners Act 2009 (NSW) s 82.

(**MTC**) pursuant to the terms of a Management Deed with the Commissioner of Corrective Services NSW (**CSNSW**). Medical care for inmates at that facility is provided by St Vincent's Hospital Sydney Limited (Correctional Health) (**SVCH**) pursuant to an agreement with CSNSW. Justice Health retains a statutory responsibility to monitor the provision of health services in managed correctional centres such as the PCC.

11. It must be emphasised that prisoners housed in privately run prisons are entitled to the same level of care as those housed in facilities directly managed by the State of NSW.
12. It should also be noted that when a person dies in custody in NSW, it is mandatory that an inquest is held.³ The inquest must be conducted by a senior coroner.⁴ When a person is detained, the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice it is especially important that the care they are offered is of an appropriate standard. Inmates should be provided with the same quality of care that they would be able to access in the community.
13. Michael was someone with pre-existing substance use issues. The issue of drug and alcohol treatment for inmates is a matter of particular concern to me and one that I have recently had cause to reflect upon.⁵ In my view, prisoners with drug and alcohol issues are placed at considerable risk if their condition is not managed in an appropriate and timely manner.

The evidence

14. The Court took evidence over five hearing days. The Court also received extensive documentary material in nine volumes. This material included witness statements, medical records, photographs, video footage, operational documents, policies, and procedures.
15. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.
16. A list of issues was prepared before the proceedings commenced.⁶ These issues guided the investigation. However, an inquest can tend to crystallise the matters which need attention and I intend to deal with the most important issues as they emerged during the proceedings under the broad headings identified by counsel assisting, which are reproduced below.

Background and brief chronology

17. Prior to the commencement of proceedings, those assisting me drafted a chronological summary of the key events from the available documentary evidence. The parties were invited to comment on this document which set out the non-controversial facts (**NCF**). I attach a copy of that document as an annexure to these reasons and do not intend to repeat all the material contained in it. I adopt its content.

³ *Coroners Act 2009* (NSW) ss 23, 27.

⁴ *Coroners Act 2009* (NSW) s 22.

⁵ *Inquest into the death of Emmett Brown (2022/00375404)* [2025] NSWCorC 38. See also *Inquest into the death of Reuben Button (2020/00257665)* [2023] NSWCorC 46.

⁶ Issues List dated 5 March 2025.

18. There was no dispute in relation to the time, date, or medical cause of Michael's death.
19. An autopsy was conducted and the results are set out in the NCF at [299]-[303].
20. Counsel assisting also produced extremely comprehensive written submissions using the NCF document and summarising much of the oral evidence. I have also relied heavily upon these submissions in recording my written reasons, at times directly adopting counsel's formulation of the material. I have reviewed the evidence carefully where differences in fact or emphasis are noted by the parties and in all matters the conclusions are my own.

Violence in NSW prisons

21. It is appropriate to state an uncomfortable truth at the outset. NSW prisons are violent environments where assaults and the possession and use of weapons is commonplace. Governor Wayne Taylor, who has worked in NSW prisons for 35 years, told the Court:

*"I don't want to sound that cavalier...but what I'm saying is violence in correctional centres is a daily occurrence. Possession of gaol-made weapons is a daily occurrence...The mechanisms we have, like segregation referrals are not perfect systems. Maybe they need some refining, maybe they don't, I don't – that's not my role to comment."*⁷

22. It is perfectly clear from this and other evidence given in these proceedings that those working within the NSW correctional environment, both in the public and private sectors, understand that daily violence is accepted as a reality in our custodial system. Its occurrence does not appear to be limited to particular high-risk sections of the custodial environment and is characterised by Governor Taylor and others as endemic throughout the system.
23. Governor Taylor saw further comment on this issue as beyond his role. While it is also likely beyond my role to say too much more, it is appropriate to record the context of Michael's death. We have created a prison system in NSW which allows high levels of violence to continue. I do not accept this is inevitable or appropriate. The view undertaken as part of these proceedings showed the degrading environment in which prisoners are kept. The evidence before this Court disclosed the overcrowding, boredom, and violence that inmates can experience. Michael's long wait for health appointments in relation to pain and his concerns about his own substance use must be viewed in the context of the known existence of a dangerous black market for drugs which operates within gaol environments. Michael's death in prison occurred in a context where frustration is everywhere and danger is commonplace. The system is deeply flawed. The reality is that our custodial environments are unsafe.

Parklea Correctional Centre

24. The PCC is classified as a maximum-security facility (a minimum-security compound, Area 4, is also situated within the PCC complex). It holds an inmate population of up to 1350 inmates. The Centre's population then and now is predominantly a remand population.

⁷ Transcript 20.3.25, Taylor, T297.24.

25. In 2020, the PCC was managed under a joint venture between private operators MTC and Broadspectrum Australia Pty Ltd (**MTC-Broadspectrum**) under an agreement made pursuant to s 238 of the *Crimes (Administration of Sentences) Act 1999*. MTC-Broadspectrum was the employer of COs who work at the PCC. MTC-Broadspectrum was responsible for instigating and managing disciplinary action in relation to their staff. Since 1 October 2022, the PCC has been operated and maintained by MTC alone.
26. The interaction between CSNSW Custodial Operations Policy and Procedures (**COPPs**) and MTC-Broadspectrum PCC Operating Policies (**POPs**) is outlined in the NCF at [4]-[5].
27. SVCH were (and currently are) contracted to provide healthcare services to inmates at the PCC.

Management of Emmett Sheard in late 2019/early 2020

Emmett Sheard's history

28. It was necessary to closely examine the management of Emmett Sheard in custody to understand whether he posed risks to other inmates which should have been managed more assertively at the time of the incident which resulted in Michael's death.
29. The following summary is drawn from that set out in the NCF at [24]-[52].
30. Mr Sheard first entered adult custody in mid-2010, then aged 18.
31. Between his entry into custody in mid-2010 and around August 2019, Mr Sheard spent about 8¾ years in custody. He had a pattern of being released from custody for short periods of time and then returned to custody again.
32. Mr Sheard has a conviction for an aggravated break and enter and commit serious indictable offence committed in July 2010. That offending involved violence and the use of a weapon. For this offence Mr Sheard was sentenced to 5 years imprisonment with a 2 year 6 month non-parole period (**NPP**). His offending in the community was otherwise for drug and dishonesty offences.
33. During his time in custody before August 2019, Mr Sheard was charged with multiple institutional misconduct offences and criminal offences. As of 2 September 2019, he had come to the attention of correctional authorities for at least 15 instances of violence or weapon related conduct.⁸
34. On 3 January 2017, while an inmate at the Goulburn Correctional Centre, Mr Sheard and two other co-accused violently attacked another inmate. While the victim was being held in a chokehold on the ground, Mr Sheard threw several punches at the victim's body and about 12 punches at his head. He only stopped when another inmate intervened. While the victim was then lying unconscious in the yard, Mr Sheard kicked him to the side of the head. For

⁸ Summarised in detail in the NCF at [47].

this offence Mr Sheard was sentenced to 22 months' imprisonment with a 16-month NPP (outlined in the NCF at [48]-[52]).

35. Mr Sheard was subject to multiple segregation directions, with the two most recent before his latest incarceration being in October 2018 and another in June 2019 for violence and weapon-possession. He had also been issued an Extreme Threat Inmate (**ETI**) verbal warning in January 2016 due to information that he "*participated in activity and/or behaviours that presented as an extreme threat to the good order and security*" of a correctional centre.
36. The ETI verbal warning was extended in January 2017 and again in June 2017 for his further involvement in violence and weapons-related conduct whilst in custody. The objective of a verbal ETI warning was to bring about behavioural improvements in the inmate. It can involve interventions and risk mitigation practices including monitoring by the Corrections Intelligence Group (**CIG**).⁹ The warning expired in July 2018.

Events between August 2019 and April 2020

37. The following summary of key events is drawn from the NCF at [32]-[40], [53]-[62], and [76]-[89] (for Mr Sheard).
38. Mr Sheard was released to parole on 12 July 2019.
39. In late August 2019, Mr Sheard returned to custody after little over one month on parole. He returned for new alleged offending in the community and non-compliance with supervision.
40. Between 26 August and 2 September 2019, Mr Sheard was housed as an inmate at the Metropolitan Reception and Remand Centre (**MRRC**).
41. On 2 September 2019, Mr Sheard was transferred to the PCC. The catalyst for his transfer to the PCC was non-association conditions put in place at the MRRC.
42. In September to October 2019, Mr Sheard was charged with the custodial offences of (1) possession of a weapon (concealed in the front of his shorts), (2) fight, and (3) possession of a weapon: see NCF at [53].
43. On 21 October 2019, Mr Sheard was placed on a behavioural management plan for seven weeks (which concluded in early December 2019): see NCF at [54]-[56]. The behavioural management plan included reference to an alert to "*violence to inmates*".
44. On 24 December 2019, Mr Sheard was being escorted by a CO through the PCC from the clinic to Area 5. Without warning, Mr Sheard approached another inmate (sweeper) and pulled a "shiv" from the front of his pants and stabbed him in his arm and ribs. Mr Sheard and the victim were unknown to one another. In late February 2020, Mr Sheard was criminally charged with the offence of reckless wounding for this conduct and he later pleaded guilty to recklessly wounding. These proceedings were not yet finalised at the time of Michael's death.

⁹ COPP 3.6 *Extreme Threat Inmate* is summarised in the NCF at [18]-[23].

Mr Sheard subsequently reported that he stabbed the inmate to avoid going back to Area 5 because he was concerned for his safety there (outlined in the NCF at [57]-[60]).

45. On 24 December 2019, in response to Mr Sheard's stabbing of another inmate on that date, an initial 14-day segregation order was issued, which was approved by PCC Governor at the time, Paul Baker, on 2 January 2020. On about 6 January 2020, that direction was extended until 23 March 2020 (a three-month period commencing 24 December 2019).
46. While subject to the segregation direction, Mr Sheard was housed in a "one-out" cell (e.g., he did not share this cell with another inmate) in a wing that housed segregated inmates. During that period, he had no direct face to face contact with other inmates. Mr Sheard, along with other segregated inmates, was subject to weekly reviews by the PCC's Segregation Review Committee (**SRC**): NCF at [69]-[75]).
47. On 31 January 2020, Mr Sheard's segregation direction was revoked: NCF at [79]-[87].
48. In February and March 2020, following Mr Sheard's return to mainstream from segregation, he was charged with three weapon-possession related offences, which included two instances of weapons being hidden in the waistband of his pants, as well as one instance of suspected of being involved in an offence of assault (outlined in the NCF at [88]).¹⁰

Management of inmates that pose a risk of violence

49. Counsel assisting summarised the key strategies utilised by CSNSW and MTC-Broadspectrum to manage the risks presented by inmates who pose a significant risk of violence to other inmates. The available strategies were:
 - Collection and analysis of intelligence or information concerning a specific inmate (e.g., the CIG).
 - Disciplinary or misconduct offences, with punishment, for disciplinary contraventions, which includes assaults on other inmates and possession of gaol-made weapons (which are not criminal proceedings).
 - Procedures for the searching of inmates and their cells for contraband (including weapons), which includes, relevantly at the PCC in 2020, a written instruction issued by the Governor concerning searching: NCF at [204]-[207].
 - Procedures and arrangements for the issuance of segregation directions on an inmate, the holding of inmates subject to segregation directions, and the review/lifting of these directions: see NCF [63]-[75].
 - Procedures for the designation of inmates, relevantly in this case, as High Security (**HS**) and Extreme High Security (**EHS**) through COPP 3.5 with determinations made by the High Security Inmate Management Committee (**HSIMC**), a subcommittee of

¹⁰ Governor Ashcroft gave evidence that he would have placed Mr Sheard back in segregation pending a full review of his placement and classification following these charges: Transcript 19.3.2025, Ashcroft, T227.9-10.

the Serious Offenders Review Council or **SORC**): see NCF at [7]-[17].¹¹ Such classifications can lead to greater restrictions on how inmates are placed, how they move, and how they interact with others in a correctional centre. HSIMC meetings are closed proceedings and they consider things such as an inmate's custodial history, intelligence holdings, and events that were the catalyst for the referral. The HSIMC will then make a recommendation as to whether the person should be classified as HS or EHS. An inmate may be subject to an interim HS or EHS designation and/or held in segregation pending a determination of the HSIMC.

- Procedures for designating or treating an inmate as an ETI through COPP 3.6, with determinations made by the Extreme Threat Inmate Management Committee (**ETIMC**). This falls within the CIG and is an internally managed CSNSW process as opposed to the externally managed HSIMC process: NCF at [18]-[23]. The ETI threshold can be established if an inmate demonstrates "violence".¹² An ETI inmate can be managed by greater restrictions on how they are placed, how they move, and how they interact with others in a correctional centre.¹³ Procedurally, an inmate is ordinarily given a verbal ETI warning before a formal written ETI notice is issued (e.g., if the inmate's behaviours do not improve).¹⁴ In his evidence, Governor Dale Ashcroft (current MRRC Governor) described where the ETI/ETIMC sat as compared to the HSIMC as: "*the ETIMC sits between segregation and HSIMC*".¹⁵
- Behavioural managements plans/contracts under COPP 3.11 (e.g., such plans/contracts are sometimes utilised when an inmate is subject to ETIMC oversight and/or is being released from segregation back into mainstream population: NCF at [22]).

50. Counsel for MTC-Broadspectrum submitted that MTC-Broadspectrum did in fact engage with a number of these strategies, including the collection and analysis of intelligence concerning Mr Sheard, the use of disciplinary or misconduct offences for possession of gaol made weapons (23 February 2020, 23 March 2020), the searching of Mr Sheard and his cell for contraband during the period 2 September 2019 and 22 April 2020, and through the use of segregation directions which held Mr Sheard apart from the general population for a period. Further, counsel for MTC-Broadspectrum noted that other strategies such as a behavioural management plan had previously been invoked and the most recent behavioural management plan, which had expired two weeks before the 24 December 2019 incident, had included reference to an alert for "violence to inmates".

¹¹ These are the two classifications relevant to this inquest. There are other classifications that an inmate can receive.

¹² "Violence" can be manifested by an inmate's involvement in extreme standover tactics (typically understood to concern organised gang standover as opposed to individual standover behaviour), and/or physical assaults on staff, inmates, or visitors; either individually or within a group: see NCF at [20].

¹³ Transcript 19.3.2025, Ashcroft, T203.

¹⁴ Ibid.

¹⁵ Ibid T223.

51. Nevertheless, counsel for MTC-Broadspectrum acknowledged that two of the key available strategies, namely referrals for consideration of designation by the HSIMC or the ETIMC, were not invoked. In written submissions, it was conceded that it would have been appropriate to consider either a referral to HSIMC or ETIMC at the time that revocation of Mr Sheard's segregation order was being considered. This was an appropriate concession. In my view, the weight of the evidence supports the view that a referral to the HSIMC or ETIMC should have been made in 2020.

Specific risk management measures utilised to manage Mr Sheard's risk of violence post the 24 December 2019 stabbing

52. The measures utilised to manage the risk Mr Sheard posed to other inmates (specific to Mr Sheard) following the 24 December 2019 stabbing were: (i) his placement in segregation; and (ii) the weekly reviews conducted by the SRC. His risks were contained in that environment.
53. The segregation direction was formally lifted on about 31 January 2020. That came about five weeks into the three-month period that was approved on about 6 January 2020.
54. At the time of its lifting, Mr Sheard had not been referred for consideration of a HS or EHS designation or issued an ETI warning after the 24 December 2019 stabbing. Nor was he required to agree to a behavioural contract or management plan upon his return to mainstream.
55. After Mr Sheard's return to mainstream on about 31 January 2020, the primary measures utilised by MTC-Broadspectrum to manage his risk to other inmates, specific to him, were intermittent targeted searches of his person and cell. In that period, Mr Sheard was found in possession of a gaol-made weapon on two occasions. Those finds resulted in disciplinary charges and sanctions. There is no evidence these events prompted consideration of him being referred for consideration of a HS or EHS designation, issuing him an ETI warning, or any other measure (e.g., behavioural management plan).
56. On 22 April 2020, at the time Mr Sheard was taken from his accommodation area and placed in the Reception Area holding cell with about 18 other inmates, he was not subject to any additional measure that provided for additional monitoring and management of the risk he posed to other inmates in terms of violence.
57. For this reason, a full examination of what led to the lifting of Mr Sheard's segregation direction, the adequacy of that decision, and whether other measures should have reasonably been utilised (e.g. referral for HS/EHS designation) before or when the segregation direction was made assumed some significance in this inquest.

Practices regarding the SRC as of early 2020

58. Part 10 of COPP 3.4 permitted the Governor (or delegate) to revoke a segregation direction if it could be determined that (i) the original threat(s) no longer exist(s) and/or (ii) an

appropriate means of eliminating the threat is available: NCF at [79]. The lifting of a segregation direction required the clear documentation of the reasons for that action: NCF at [80].

59. As a matter of practice, the Governor usually maintained, extended, or lifted segregation directions on the recommendation of the SRC.
60. Correctional Supervisor Warwick Aston (**Supervisor Aston**), Area Manager Anthony Mott, and Andrew Redden (MTC-Broadspectrum Psychologist) were employed at the PCC as of January 2020 and gave evidence about the SRC's practices as of January 2020. In summary:
 - i. The SRC typically consisted of Megan Lawlor (Acting Deputy Governor as of early 2020) who typically acted as the head of the SRC and a manager of each wing within the gaol that had inmates being held in segregation (if available to attend).
 - ii. The Governor (Paul Baker) sometimes attended SRC weekly reviews but he regularly delegated that responsibility to Megan Lawlor.
 - iii. In preparation for the weekly SRC review, a document was prepared that listed the inmates in segregation and included limited details concerning their placement there.
 - iv. As part of the weekly reviews, the SRC would walk by each cell in the segregation area and briefly engage the subject inmate. Members of the committee did a walk around and saw the inmates cell by cell. An example of the documents (referred to as "Minutes") prepared for the SRC's reviews on 16 and 23 January 2020 is annexed to Governor Taylor's statement dated 21 February 2025¹⁶ which lists the attendees for the 23 January 2020 review as "*M.Lawlor, Sau Tagaloa, Anthony Mott, Andrew (Psychologist) and St Vincent's nurse*".
 - v. The SRC members were taken on this walkthrough by the Correctional Supervisor responsible for the Segregation Area when the review took place. That Supervisor might be asked by the SRC for information about the inmate's behaviour since the last review but was not part of the SRC decision-making.
 - vi. A SVCH representative (nurse) typically accompanied the SRC during its weekly walkthrough of the segregation inmates but was not part of the SRC decision-making. The SVCH representative was on hand to assist an inmate if he had a medical request.
 - vii. An MTC-Broadspectrum psychologist on occasion also accompanied the SRC during its weekly walkthrough, however, there was limited capacity for this to occur in early 2020. Mr Redden gave evidence that when he attended, his role was to check on the psychological welfare of the inmates. He did not participate

¹⁶

Statement of Wayne Taylor dated 21.2.2025: Vol 3B, Tab 202A, pp. 22-31.

in decision-making of the SRC.¹⁷ His attendance “*became intermittent...because of the requirements, there were two psychologists of a goal of approximately 1,000 inmates, so the priority was risk management and court reports. So I tried to attend on a weekly basis, but it wasn't always possible.*”¹⁸

- viii. At the completion of the walkthrough and discussions, an SRC member would complete a written recommendation for the approval of the Governor, for instance, recommending the lifting of a segregation direction and any other proposed measure, if any (e.g., the lifting of the direction being conditional on the inmate entering a behavioural contract).
- ix. Outside their own personal knowledge of a specific inmate (if any), the SRC’s recommendations would be based on: (i) what was recorded in the “Minutes” document; (ii) any verbal information provided by the Segregation Correctional Supervisor; (iii) information provided by the inmate verbally during the walkthrough; and (iv) other information drawn from the Offender Integrated Management System (**OIMS**) (if an SRC member proactively checked an inmate’s OIMS records) which may include daily case notes made by segregation officers based in the segregation area. In Mr Sheard’s case, the daily case notes made by the officers supervising him in segregation were almost identical each day.
- x. In some instances, inmates can transition from segregation by way of stepdown, which might involve placement in different areas within the Correctional Centre (e.g. another wing/pod) or transfer to another correctional centre.

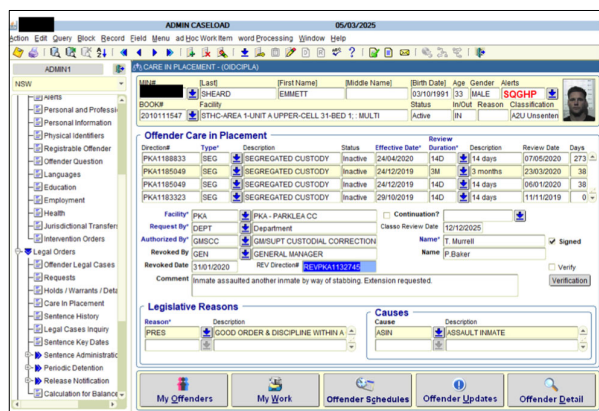
Available records regarding the lifting of Mr Sheard’s segregation direction

61. For this inquest, MTC-Broadspectrum reviewed its records for documentation concerning the lifting of Mr Sheard’s segregation direction on 31 January 2020, and the reasons underlying that decision.
62. The formal revocation/lifting of the direction was recorded within the OIMS on 31 January 2020 (Care in Placement Module). The available electronic record lists the direction as “[r]evoked” on that date:¹⁹

¹⁷ Transcript 19.3.2025, Redden, T267-268.

¹⁸ Ibid T268.

¹⁹ Annexure 2 to the statement of Anthony Mott dated 12.3.2025: Vol 3B, Tab 201B, p. 10.



63. As for the formal instrument approving the lifting of the segregation direction on 31 January 2020, the only form located was an unsigned document on Mr Sheard’s custody file reproduced below:²⁰

Pursuant to Part 2 – Division 2 Crimes (Administration of Sentences) Act 1999

Date of initial direction: 24/12/2019 Direction No. PKA1185049

MIN: [REDACTED] SURNAME: SHEARD Name: EMMETT DOB: 3/10/1991

Revocation of segregated custody

In my opinion segregated custody of this inmate is no longer necessary to secure the:

personal safety of any other person

security of a correctional centre

good order and discipline within a correctional centre

Comments/reasons:

The segregated custody direction, which initially commenced on [REDACTED] is hereby revoked.

Signature: _____ Date of revocation: _____

Revocation direction No. _____

Note: If the inmate to whom this direction relates has applied to SORC for a review of the direction and that review has not yet taken place, please fax a copy of this revocation to the Executive officer, SORC on (02) 8598 8090 and the Senior Legal Officer, General Counsel on (02) 8546 1804 or email general-counsel@correction.nsw.gov.au

64. As can be seen, the only indication on this form as to the possible reason for the lifting of the segregation direction is that the opinion of someone (unidentified) was that it was no longer necessary to continue Mr Sheard’s segregation in order to secure the “good order and discipline within a correctional centre” (indicated by way of cross). The reasons for that view are not documented, even briefly, on the form. No other record or document has been located that outlines the reasons for the approval being given for the lifting of the segregation direction.

65. MTC-Broadspectrum did not locate any record or document setting out the reasons for the formal lifting of the direction on 31 January 2020.

66. The formal lifting of the segregation direction was either done pursuant to a recommendation of the SRC on 30 January 2020 or was otherwise an action taken by one of those members who attended the walkthrough or “informal” meeting on 30 January 2020 (who held delegation from the Commissioner). This is based on the following evidence:

- i. An OIMS note was entered by the Segregation Supervisor for Mr Sheard that recorded: “Seen by Seg Review Committee today. Seg to be revoked shortly”.²¹

²⁰ Annexe 3 to the statement of Anthony Mott dated 12.3.2025: Vol 3B, Tab 201B, p. 14.
²¹ Sheard OIMS case notes – April 2017 to April 2020: Inquest Hearing Exhibit 4, p. 80.

- ii. The evidence of Anthony Mott who frequently attended SRC weekly meetings in early 2020. Mr Mott gave evidence that, based on his review of his diary, he believes a SRC weekly meeting was scheduled for the morning of 30 January 2020 but that *“the formal [SRC] meeting that was planned for 30 January 2020 may have been postponed to 31 January 2020 due to the unavailability of Area Managers to attend on 30 January 2020. The cell visits may still have taken place on 30 January 2020 with a more limited team of SRC members.”*²² Mr Mott further gave evidence that (in his statement to the inquest):²³

“I received a copy of the SRC minutes for 31 January 2020. [Annexure 1] is a copy of the SRC minutes for 31 January 2020 and the email under which I received the minutes. The minutes have been redacted so that they do not reveal the details of other inmates.

The SRC minutes for 31 January 2020 do not record any discussion in relation to inmate Sheard. It appears to me based on those minutes that the decision to revoke the Segregation Direction might have been made at the cell walk around on 30 January 2020.” (emphasis added)

67. The Minutes completed for an SRC meeting on 31 January 2020 are annexed to the statement of Anthony Mott.²⁴ In addition to containing no reference to Mr Sheard, this document does not record who the “attendees” were for that meeting.
68. MTC-Broadspectrum has not located Minutes for a SRC meeting held on 30 January 2020.
69. Governor Taylor gave evidence as to the conclusions he reached on his review of the available records as to the basis of the lifting of the segregation direction, noting he did not hold a position at the PCC in 2020 and was not involved in this decision. In his supplementary statement for the inquest, Governor Taylor said:²⁵

“As the OIMS case note indicates, Mr Sheard’s segregation order was reviewed during the weekly SRC meeting, and the SRC determined that Mr Sheard was to return to his general housing.

...

I am unable to say for certain who was part of the SRC on the date in question as the minutes of the meeting have not been updated to reflect that information.

...

*In my experience, SRC minutes generally record the outcomes of the committee’s deliberations and not the reasons for those outcomes. I am unable to locate any additional information for the decision for the revocation of Mr Sheard’s segregation order. **It appears to me that the electronic meeting minute for 30 January 2020 was overwritten when a subsequent meeting took place.**”* (emphasis added)

Matters the SRC/decision-maker may have considered in determining whether to lift the segregation direction

70. Area Manager Aimee Flynn, who worked at the PCC in January 2020 and was sometimes involved in weekly SRC reviews at the PCC, and Governor Taylor gave evidence as to the

²² Statement of Anthony Mott dated 12.3.2025: Vol 3B, Tab 201B, [7]. See also Transcript 21.3.2025, Mott, T366-367.

²³ Statement of Anthony Mott dated 12.3.2025: Vol 3B, Tab 201B, [8]-[9].

²⁴ Ibid pp. 5-9.

²⁵ Supplementary statement of Wayne Taylor dated 21.2.2025: Vol 3B, Tab 202A, [29]-[30], [38].

types of matters the SRC typically considered in determining whether to recommend the lifting of a segregation direction. Governor Taylor's expectations around this is based on his experience working with CSNSW, including at the level of General Manager and Manager of Security at Correctional Centres operated by CSNSW, and his current position as Governor of the PCC.

71. CO Flynn, when asked what was involved in making or approving a three-month extension (such as the one she made for Mr Sheard on 2 January 2020 as Area Manager at the time), said in evidence:²⁶

"So you'd look at the offence, how long they've been in segregation for, and then you would make a recommendation based on that... [t]he offence, so why they were put into segregation in the first place. Their behaviour in that segregation time, so if they've been compliant, if they haven't been, they're pretty much the standards that you kind of look at."

72. Governor Taylor expected the SRC would have considered whether the inmate acknowledged his wrongdoing and indicated a willingness to comply in future and, possibly, whether some sort of behavioural management plan or contract ought to be put in place and if there were any referrals made, whether it be psychology or other support services.²⁷

73. As regards to what he expects underpinned the lifting of the segregation direction in Mr Sheard's case, Governor Taylor gave evidence (through his supplementary statement):²⁸

"Based on the minutes of the SRC for 16 and 23 January 2020 it appears that inmate Sheard's level of compliance was to be considered during the weekly reviews of his segregation. Document 3 is an extract of the SRC minutes relating to inmate Sheard for 16 January 2020 and 23 January 2020.

Inmate Sheard's level of compliance was assessed and case noted regularly during this period of segregated custody. Document 4 is a printout of case notes concerning inmate Sheard for the period 24 December 2019 to 30 January 2020 (inclusive).

*COPP 3.4 permitted a Governor or delegate to revoke a segregation direction if it could be determined that the original threat(s) no longer exists or an appropriate means of eliminating the threat is available. Based on my review of the extract of the SRC minutes relating to inmate Sheard and the case notes to which I have referred above, it is probable that the SRC lifted the segregated custody direction **on the basis that inmate Sheard's behaviour while he was held in segregation demonstrated that the original threat on which the direction was made no longer existed.** I also note that by 30 January 2020 the inmate who inmate Sheard had assaulted was housed in an area separate from inmate Sheard's proposed housing location. This may have been a factor in the SRC's decision." (emphasis added)*

74. The case notes referred to by Governor Taylor in his statement (Document 4) were the daily OIMS reports completed by the Segregation Supervisor. These reports are very limited and largely replicate themselves day to day (e.g. stating to the effect: "Compliant with wing routine. Nil issues.").²⁹ The Minutes for the reviews on 16 and 23 January 2020 (Document 3) also contain scant detail about Mr Sheard's circumstances and progress.³⁰

²⁶ Transcript 18.3.2025, Flynn, T135.24-25 and T136.15-17.

²⁷ Transcript 20.3.2025, Taylor, T292-293.

²⁸ Supplementary statement of Wayne Taylor dated 21.2.2025: Vol 3B, Tab 202A, [35]-[37].

²⁹ See case notes in Annexure WT-4 to the supplementary statement of Wayne Taylor dated 21.2.2025: Vol 3B, Tab 202A, pp. 32-39.

³⁰ The Minutes for 16 January 2020 recorded *"inmate to be of Good Behaviour. Inmate to be reviewed weekly. Inmate OIC completed 56 days off amenities. Inmate asked to follow up on photos/mail"* and the Minutes for 23 January 2020 recorded

75. An additional matter that is weighed in decision-making is the impact on the inmate in continuing the segregation direction. Continuing isolation from other inmates over the medium to long term is likely to be detrimental to an inmate's emotional and psychological wellbeing and the inmate's general rehabilitation. It is accepted this is an important matter to be given weight.

Absence of documentation as to the reasons for lifting the segregation direction

76. The absence of contemporaneous records of the reasons for any recommendation by the SRC for lifting of the segregation direction and/or of the reasons for the final decision to approve its lifting is concerning.
77. This documentation is intended to capture important risk management assessments and decision-making. It provides a contemporaneous record of what was considered.
78. The exercise of documenting a reasoning process also focuses the decision-maker's mind on the evaluation process and permits scrutiny of the decision.
79. Counsel assisting submitted that the unavailability of the records hinders my ability to ascertain what matters were in fact considered in Mr Sheard's case and how competing factors might have been weighed in the decision to lift the direction. I agree that the lack of records makes it difficult for me to be certain about what drove the final decision, but in my view the problem is somewhat deeper. The review process, as it was described by those who had participated in the walkthrough meetings, appeared very superficial. There was no real participation by a psychologist and on the accounts given, little curiosity about future behaviour was demonstrated beyond ascertaining whether the CO had identified daily "compliance" in the segregation placement. While I accept the practical difficulties conducting formal meetings in these circumstances, the decision about whether to keep a prisoner in segregation is an important one with serious implications for the prisoner and others. Great care should be taken with such decisions and the reasons should be recorded.

Should the segregation direction have been lifted on 31 January 2020?

80. Counsel assisting submitted that I would be comfortably satisfied that the segregation direction should not have been lifted on 31 January 2020 without at least some other measure being instituted (e.g. referral for HS/EHS classification).
81. He submitted that this is not a conclusion merely reached with the benefit of hindsight. It takes into account the information that was known or reasonably available to the SRC/formal decision-maker. He raised a number of matters for consideration, which I refer to below.
82. *First*, prison environments are inherently violent environments given that they hold numerous inmates in a confined area where boredom is rife, with many inmates being held for alleged

"Inmate to be of Good Behaviour. Inmate to be reviewed weekly. Follow up on photos/mail (Warwick to action). Property advised of backlog in processing. Inmate at AVL when seg review completed. Inmate extended": See Exhibit WT-3 to the supplementary statement of Wayne Taylor dated 21.2.2025: Vol 3B, Tab 202A, pp. 23, 28.

or actual violent offending or otherwise having a history of violent offending. Even with reasonable allowance for that fact, Mr Sheard's history and circumstances pointed to a high likelihood of him being involved, or committing, further acts of serious violence, possibly with a gaol-made weapon, on his return to the mainstream population. The risk he posed to other inmates was significant both as to the likelihood of him committing a violent act and the potential magnitude of harm if he did.

83. Mr Sheard had incurred numerous disciplinary offences for violence and possession of gaol-made weapons. He had also been convicted of committing a serious and sustained assault on another inmate in January 2017. He had a demonstrated propensity for obtaining, and carrying on his person, gaol-made weapons. That propensity increased the magnitude of injury he was capable of inflicting in an act of violence.
84. Mr Sheard stabbed another inmate who was unknown to him on 24 December 2019. This occurred with no provocation on the victim's part. This constituted a brazen instance of violence, committed in view of officers, without concern for the consequences to himself or, evidently, the victim. Even though Mr Sheard had not been criminally charged for this act as of 31 January 2020, it had been witnessed by CO/COs, if not captured on CCTV footage. It is not known if COs, at the time of the incident, ascertained the motive for his act. The absence of a proper understanding of his motive would itself have been a concern in assessing the likelihood of him committing further acts of violence in the near future. If his subsequently reported motive, that he did so to avoid being placed in a particular area, was known, it would be of significant concern that he was willing to stab an inmate to secure that objective.
85. The portion of Mr Sheard's adult life spent in custody pointed to his difficulties in remaining offence-free or complying with parole during the short periods he was out of custody. As of January 2020, he bore the hallmarks of institutionalisation. He had been subject to numerous segregation directions in the past and previously managed under a verbal ETI warning (2016-2018) and behavioural management plan (as recently as October to December 2019). These measures had not deterred his propensity for violence or brought about sustained behavioural change.
86. *Second*, it is unlikely the SRC received an expert psychological opinion from Mr Redden or the other MTC-Broadspectrum employed psychologist employed at the time regarding Mr Sheard's stability and risk of further violent offending. If he was able to attend the review on 30 January 2020, his role was limited to checking on Mr Sheard's psychological welfare rather than providing expert input to the SRC's decision-making. Consistent with that fact is that there is no record (OIMS note or otherwise) in which Mr Redden recorded the fact of him assessing Mr Sheard or offering any opinion as to his future risk.
87. *Third*, accepting Mr Sheard was compliant and did not pose a management difficulty in segregation, limited weight could be placed on that fact given he was not in direct contact

with any other inmate while in segregation. The information recorded in the daily OIMS notes offer no meaningful insight into what Mr Sheard's attitudes were or the risk he posed of committing further serious acts of violence on his return to mainstream. It is difficult to conceive:

- i. How Mr Sheard's compliance in segregation itself would have caused the SRC/decision-maker to conclude he no longer posed a material threat to other inmates in mainstream; or
 - ii. What confidence the SRC/decision-maker could have had in any assurance Mr Sheard might have given that he would comply with correctional centre routine if permitted to return to mainstream (assuming he gave such assurances during his interaction with the SRC in the weekly review), given the circumstances of the 24 December 2019 stabbing and his history.
88. *Fourth*, accepting that the victim of the 24 December 2019 stabbing had been moved to another area by 30 January 2020, meaning he himself would not be in direct contact with Mr Sheard if the segregation direction was lifted, little confidence could be derived from that fact as regards the risk Mr Sheard posed to other inmates.
89. *Fifth*, accepting that the impact of Mr Sheard remaining in segregation was a matter to be legitimately considered, at the point the direction was lifted he was five weeks into a three-month period. This factor, of itself, could not outweigh the protection of other inmates/persons or justify the lifting of the segregation order without any other measure being instituted.
90. *Lastly*, both Governor Ashcroft (the current Governor of the MRRC, operated by CSNSW) and Governor Taylor (the current Governor of the PCC, operated by MTC) were asked to express their views on the action they themselves would have taken on about 30 January 2020 having regard to the 24 December 2019 stabbing and Mr Sheard's history (set out in the list of assumptions' document.³¹
91. Governor Ashcroft gave evidence that, as of 30 January 2020, had Mr Sheard been at the MRRC under his (Governor Ashcroft's) responsibility, he would have made: "*a referral to the HSIMC for security protocols because...he does present as an extreme threat to the safety of a person*". He said that he would have kept Mr Sheard in segregation until the referral to the HSIMC "*went through and there was a decision made by the Commissioner and SORC as to what they were going to do*".³² Governor Ashcroft agreed that the review the HSIMC would undertake would also permit a more comprehensive evaluation of Mr Sheard's risks.³³
92. Given that Mr Sheard had already received a verbal ETI warning in the past (2016-2018), Governor Ashcroft would have opted for a referral to the HSIMC rather than to the ETIMC.

³¹ Inquest MFI-C.

³² Transcript 19.3.2025, Ashcroft, T225-227.

³³ Ibid.

Depending on the designation determined by the HSIMC, there would potentially be more placement options for Mr Sheard. For instance, an EHS designation would provide for “one-out” placement.³⁴

93. Governor Taylor, in his evidence, said “*in retrospect in hindsight*” he possibly would have referred Mr Sheard to the HSIMC before lifting the segregation direction but did not go so far as to agree that this was something that clearly should have occurred.³⁵ Counsel assisting drew my attention to Governor Taylor’s evidence in this regard:³⁶

“Q. So in hindsight, do you think there should've been a referral to the HSIMC?”

A. Yes.

Q. What about consideration of keeping him in segregation?”

A. That's a different matter. So you could've done the two, you could've let him out and still made the referral. If the referral said - again, this is my reflection and hypothetical - if I was making a case to the HSIMC that this man is dangerous and he can't go out into the main, again, I would put that in my justifications for approval, ongoing approval for seg, because then I'd be deflecting by saying I've made a referral to the HSIMC. Until they sat on that matter, that would justify me extending the seg.

Q. Yes. I understand you weren't in charge at the time, but I've also had the benefit of another very experienced governor. So I've had Mr Ashcroft here-

A. Yes.

Q. --and you know he's governor of MRRC--

A. Yes.

Q. --I'm sure you've probably even worked together.

A. Yes.

Q. Two very experienced people, and Mr Ashcroft's evidence when taken through the same thing was, this isn't borderline, it should've gone to the HSIMC. So I'm trying to grapple with opinions and understand your opinion, and certainly now you've said with hindsight going to the records, you yourself, if you'd been in that position think that should've been done?

A. Your Honour, if I can clarify?

Q. Yes.

A. I acknowledge yes in hindsight, I agree. So I think that puts me in alignment with my colleague. What my position is, is in this case it's quite difficult for me to look on reflection and some of the points that your Honour's raised I think that there's no documentation of the pathway. Again, so all you've got to go with is the raw material, but in my business I would pull all that apart and I would have on each incident a synopsis of what the causal effects were. Whether, you know, whether the inmate agreed with them, so there's a lot. What I'm saying, violence is not just violence. Yes, there are people in this world that are just violent and they are violent for no other reason than being violent, but again, in my business, and even when I make a referral, I want to get as much, it doesn't have to be fact, it could be intelligence-based, of what the motives for that violence were. That allows people to make an informed risk assessment.”

94. Governor Taylor, in his evidence, did not impugn the reasonableness of the opinion expressed by Governor Ashcroft in this respect.
95. To the extent there is any difference in the opinions of Governor Ashcroft and Governor Taylor on the issue of whether a referral to the HSIMC should have been made and whether Mr Sheard should have remained in segregation pending that determination, counsel assisting

³⁴ Transcript 19.3.2025, Ashcroft, T223.39-50.

³⁵ Transcript 20.3.2025, Taylor, T295.40-48.

³⁶ Ibid T298-299.

submitted that I would prefer the opinion of Governor Ashcroft. That submission takes into account the seriousness of the 24 December 2019 stabbing event, which was unprovoked and committed in view of officers by an inmate with a long history of violence in custody and who had been subject to numerous segregation orders and other measures in the past.

96. Further, counsel assisting submitted I would be satisfied that the thresholds for HS or EHS were capable of being satisfied on or before 30 January 2020 even without regard to the opinions expressed by Governor Ashcroft,³⁷ and that there was a high likelihood, in all the circumstances, the HSIMC would have approved a referral, at least for a HS designation.
97. Counsel assisting submitted that the decision not to refer Mr Sheard to the HSIMC, and keep him in segregation pending that review, was a significant missed opportunity to evaluate the risk he posed to other inmates in mainstream population and to implement measures to mitigate those risks. That may have included monitoring and conducting searches of him and imposing restrictions on his contact with other inmates (including when he was temporarily placed in holding cells with other inmates).
98. MTC-Broadspectrum made detailed submissions in relation to the management of the segregation issue. I have considered them carefully. Overall, counsel for MTC-Broadspectrum submitted that counsel assisting's submissions on this issue involved a considerable degree of hindsight analysis and an approach which gave undue weight to matters such as historic issues which the SRC may not have considered at the relevant time.
99. While counsel for MTC-Broadspectrum conceded that with hindsight it would have been appropriate to consider either a referral to HSIMC or ETIMC, it was not conceded that the revocation of the segregation order was similarly straightforward. While Governor Ashcroft stated that on what he knew he would have kept Mr Sheard in segregation,³⁸ counsel for MTC-Broadspectrum cautioned the Court into accepting that this was put forward as a "mandatory position" given Governor Ashcroft's qualification that he did not know the PCC environment.
100. Counsel for MTC-Broadspectrum cautioned against the making of adverse findings in relation to aspects of this issue when a lack of documentation and the unavailability of certain witnesses means the Court does not have clear evidence about the way risk was actually assessed at the time of lifting the segregation order. It was acknowledged that the only indication as to the reason for lifting the order was that it was no longer necessary to secure the "*good order and discipline within a correctional centre*" indicated by a cross. This form, which is a CSNSW form rather than one specific to MTC-Broadspectrum, offers no space for recording reasons and it was submitted that it is "unlikely" that it was the primary or exclusive record of the reasons.

³⁷ Definitions of HS and EHS are set out in the NCF at [11]-[13].
³⁸ For discussion of this issue see Transcript 19.3.25, Ashcroft, T225.34 and onwards.

101. While cautioning against firm findings where the “likely” documentation was not available, MTC-Broadspectrum nevertheless acknowledged the deficient documentation was less than ideal.
102. At the same time, it was submitted that it must be remembered that segregation is a process which sits between internal disciplinary offences and external criminal charges. While directions and orders are imposed at the discretion of corrective staff and require approval by the Governor, it is not expected that the process is attended by great formality. Counsel for MTC-Broadspectrum submitted that the segregation process depends to some extent on informality and does not require an extensive or formal in-depth risk management assessment.
103. Counsel for MTC-Broadspectrum urged the Court to accept that in 2020 the risk considered for the purpose of lifting segregation orders under Part 10 of COPP 3.4 was focussed only on the specific risk arising directly from the original threat rather than encompassing a broader consideration of future similar risks. I am not convinced that this very narrow reading of how risk should be assessed is correct. However, if this is how decisions are actually made, it demonstrates an approach which is in my view overly artificial.
104. Counsel for MTC-Broadspectrum submitted that the purpose of the segregation order was to deal with the discrete threat or risk relating to the incident which triggered the order and was not expected to be a broad ranging risk assessment. It was submitted that the Court should take notice of the fact that segregation is not a process which is intended to address a broad management approach to all risks associated with an inmate’s accommodation in the general population.
105. While it was conceded that the available evidence did not establish the reason the segregation order was lifted, counsel for MTS-Broadspectrum asked me to give careful consideration to Governor Taylor’s evidence that it is probable that the SRC lifted the segregation order on the basis that the original threat on which the direction was made no longer existed. That is, specifically, that by 30 January 2020 the inmate that Mr Sheard had assaulted was housed in a different area of the gaol.
106. Overall, I accept that I am hampered by the lack of evidence in relation to the reasons for the decision being made to lift the segregation order. Nevertheless, even if the original and specific threat had been neutralised by the movement of the prisoner who had been assaulted, I do not accept on what is before me that it was appropriate to lift the direction. I am comfortably satisfied that the lifting of the direction was premature in circumstances where there was no referral for consideration of HS/EHS classification and no recorded consideration of a behavioural management plan.

Events between 1 February and 22 April 2020

107. There were additional missed opportunities after the lifting of the segregation direction on 31 January 2020 when Mr Sheard was found in possession of gaol-made weapons on 23 February 2020, very soon after his release from segregation for the 24 December 2019 stabbing event. Mr Sheard was taken off contact visits for 42 days.
108. On 10 March 2020, Mr Sheard and another inmate were possibly involved in an incident without the use of weapons. Each inmate reported that they “slipped in the shower” and there was insufficient evidence upon which to proceed.
109. On 25 March 2020, Mr Sheard was once again found in possession of a gaol-made weapon. The charge was heard on 15 April 2020 and the penalty imposed was 42 days suspension off buy ups, which was subsequently rescinded for reasons the Court is unaware of.
110. Counsel assisting submitted that these events are concerning given his recent stabbing of an inmate in late December 2019 and the more recent release from segregation. They underscore the limited weight that could be given to any assurance given by Mr Sheard that he would comply with PCC routine if permitted to be in mainstream.
111. Although disciplinary charges were laid, disciplinary sanctions were imposed, and Mr Sheard was subject to targeted searches in this period, it appears no consideration was given to referring him to the HSIMC owing to these developments. He remained in mainstream population until 22 April 2020. I note that both Governor Taylor³⁹ and Governor Ashcroft gave evidence that with the benefit of hindsight an alternate approach could have been taken.
112. Counsel assisting submitted that the efficacy of the reliance on targeted searches to mitigate the risk Mr Sheard posed is also brought into question by specific facts disclosed in this case. Several gaol-made weapons were carried by inmates when they were taken from their accommodation area and placed in the Reception Area Holding Cell on 22 April 2020. Three weapons were found and seized in the Reception Area in the immediate aftermath of Michael’s death. It appears that the inmates that had weapons on their person were not deterred by the possibility these would be located, whether because they expected they may not be searched or that such a search would not result in the weapon being found.
113. The items found during a search of Mr Sheard’s cell after Michael’s death were also particularly concerning. In addition to multiple gaol-made weapons found in his cell (NCF at [323]), numerous items were also found including materials from which weapons could be readily made: see NCF at [324]-[325]. Even accepting the weapons were not in open view within the cell, it is difficult to conceive the other items (containers, etc) could have escaped the notice of COs. This is of concern, particularly given Mr Sheard’s history for possession of

³⁹

weapons and his recent violence. The amount of items in his cell points to a breakdown in the supervision that inmates like Mr Sheard were receiving in terms of their cell content.

114. Having considered all the available evidence, I accept counsel assisting's submission that there were significant missed opportunities to properly assess and manage Mr Sheard's risk in the period 24 December 2019 until 22 April 2020.
115. Counsel assisting put forward two draft recommendations arising from the evidence relating to the management of risk associated with Mr Sheard. The draft recommendations are aimed at improving current practises and training in relation to the lifting of segregation orders, including improvements to record keeping and file management. Counsel assisting also urged that consideration be given to the circumstances where a referral to the HSIMC should be considered. The draft recommendation suggested MTC review its procedures, instruction, and training in this regard.
116. The draft recommendations were supported by counsel for MTC-Broadspectrum. In fact, it was submitted that a review has already commenced. The Court was informed that the process is now strictly adherent to COPP 3.4. There has already been a change to the review process, which includes the preparation and circulation of minutes. The Court was advised that meetings of the SRC are no longer held at cell doors and are attended by relevant custodial managers, SVCH representatives, psychologist service representatives, and the Governor or Deputy Governor.
117. The Court was also informed that a training pack is to be developed and implemented with a focus on referral for redesignation as ETI or referral to the HSIMC as a management tool for risk associated with inmates who are identified as having a history of violence or security risk.
118. The Court was also informed that following the exploration of these issues in this inquest, CSNSW has given fresh consideration to improving systems concerning the management of inmates with a history of institutional violence. It was pleasing to know that CSNSW indicated that it is presently exploring the feasibility of including prompts in the Incident Reporting Modules that COs complete when a violent incident occurs in a correctional centre. These prompts would assist COs by reminding them of available options that may be appropriate.
119. Counsel for the Commissioner of CSNSW stated the prompts would include asking COs to consider whether it would be appropriate to include alerts in OIMS, such as "*assault cellmate*", "*assault inmate*", or "*must be housed 1 out: serious assault on cellmate whilst locked in cell*". COs would also be reminded by alert to consider referral to ETIMC, HSIMC, or an appropriate service including CSNSW psychologist or SAPO.
120. If such prompts were included, it would also be a requirement that a Senior Assistant Superintendent act as a reviewing officer for any decision to re-house an inmate as a result of the prompts.

Escort of AVL inmates to Reception on 22 April 2020

Inmates not searched on 22 April 2020

121. PCC currently has (and had at the relevant time) a number of ways to scan inmates, including handheld wands (which detect metal and can be used for various searches including during internal movements), Milliwave scanners (which also detect metal and are used as staff and visitors enter the facility and which are also located at various locations in the facility), and a body scanner used in Reception and in visitors areas (which detect foreign objects within or on the body and which emit radiation, which means that inmates can only be scanned by this method a limited amount of times every year).
122. In May 2019, MTC-Broadspectrum's procedures concerning the searching of inmates was governed by MTC-Broadspectrum POP 4.05 Searching (v3)⁴⁰ and MTC-Broadspectrum Governor's Written Instruction - Searching (May 2019) (**Search Instruction**).⁴¹ The Search Instruction, which itself referred to the CSNSW COPP 17.1, provided:
- "Effective immediately, all inmates exiting accommodation areas for internal/external escorts - which includes but is not limited to property runs, medical appointments, visits, AVL, court will be screened using a handheld metal detector and pat searched.
Hand-held wands have been issued to all respective areas. See your Area Manager or Supervisor if you require further training or instruction."*
123. The Search Instruction did not specify stipulations regarding searches on male inmates by female officers or vice versa.
124. COPP 17.1 *Searching Inmates*, which existed as of 22 April 2020, provided that female COs should not pat search male inmates.⁴² It read: *"Correctional Officers must not pat or strip search inmates of the opposite sex, except in exceptional circumstances or emergencies. Approval must be sought from the Governor or a delegated officer if this is to occur."*
125. On 7 March 2020, a reminder email was sent to all custodial staff that read:
- "Due to the high number of makeshift weapons being located and reported during this period, its [sic] a timely reminder to staff that all inmate movements in and out of your respective accommodation units must be subjected to a Pat Search and where possible supported with the use of a Handheld Metal Detector (Wand)".⁴³*
126. None of the inmates who were escorted from Area 5 to Reception on 22 April 2020 were searched. This was a missed opportunity to identify that some of them were in possession of gaol-made weapons (shivs).
127. It was common evidence amongst witnesses in the hearing that gaol-made weapons were prevalent at the PCC. Immediate Response Team (**IRT**) member Nathan Schwenke gave evidence that *"[s]tabbing[s] happen all the time, so like, stabbing[s] are common"*.⁴⁴

⁴⁰ MTC-Broadspectrum Policy 4.05 Searching (v 3): Vol 5, Tab 223.

⁴¹ MTC-Broadspectrum Instruction – Searching (May 2019): Vol 5, Tab 241.

⁴² COPP 17.01 *Searching Inmates* (March 2023): Inquest Exhibit 3.

⁴³ Supplementary statement of Wayne Taylor dated 19.3.2025: Vol 3B, Tab 202AA, p. 30.

⁴⁴ Transcript 18.3.2025, Schwenke, T163.

What happened with the search

128. COs Tori Welsh and Luke Everett escorted Michael, Mr Sheard, and other inmates from Area 5 to the Reception Area in their duties as “rovers” on 22 April 2020. No pat down search of the inmates was undertaken by either of them.
129. CO Welsh had been a correctional officer at the PCC for just over one year as of 22 April 2020. It was her first role as a CO. CO Everett was junior to CO Welsh, having only commenced in his first role as a CO about three weeks before 22 April 2020.
130. CO Welsh’s evidence was that it was practice to pat search inmates as soon as they exit the chutes before proceeding to Reception.⁴⁵ CO Welsh was of the understanding, however, that female COs could not pat search male inmates unless directed by the Governor.⁴⁶ CO Welsh stated that the rule preventing female COs from pat searching male inmates was contained in the relevant COPP (COPP 17.1), which was available on an internal website (SharePoint) for PCC COs to read. She had not read COPP 17.1 herself but was aware of what it stipulated as regards same sex pat searches.⁴⁷
131. CO Welsh’s understanding accords, in substance, with COPP 17.1. Her understanding about this was consistent with multiple other PCC COs who gave evidence in the hearing.
132. CO Welsh did not recall having a conversation with CO Everett about pat searching the inmates. She accepted that she could have either spoken to her supervisor that day or asked Mr Everett to do the pat searches.⁴⁸ She said that on other occasions she had asked her supervisor to get a male officer to conduct a pat search.⁴⁹
133. CO Welsh said that she had thought that CO Everett was going to pat search the inmates at the end of the chute,⁵⁰ however, she did not have a line of sight to CO Everett at the other end of the chute and she did not expressly ask or confirm with him that he had searched the inmates.
134. CO Welsh said that wand searching was in place for the escort of inmates within the PCC as of April 2020, but that it was not a common procedure practiced by officers.⁵¹ CO Welsh also said that the wands were unreliable, including due to their batteries, and did not always work so there was limited availability of them.
135. CO Everett’s evidence was that he was not aware that there was a procedure requiring a pat down search to be completed upon escorting inmates to Reception. When he was at the other

⁴⁵ Transcript 17.3.2025, Welsh, T22.

⁴⁶ Ibid T19.

⁴⁷ CO Welsh said that the COPPs were there and available to be read, but that she had never been directed to read them, and there was no method, to her knowledge, whereby PCC management confirmed that staff had read policy and procedure documents. CO Everett gave evidence that after 22 April 2020, the searching policies and procedures at the PCC were sent out via email and COs were required to sign off on them.

⁴⁸ Transcript 17.3.2025, Welsh, T26.

⁴⁹ Ibid.

⁵⁰ Ibid T34.

⁵¹ Ibid T16.

end of the chute he did not realise or understand he was expected to conduct a pat down or wand search of the inmates before they left the chute area.⁵²

136. CO Everett had only completed his basic training a matter of weeks prior to 22 April 2020. As at 22 April 2020, he appeared to have been unaware that there was a procedure in place at PCC which required inmates were searched on internal transfers.⁵³ Further, he told the Court that was not aware that there was any prohibition on female COs pat searching male inmates.⁵⁴

Findings as to the failure to search

137. CO Welsh accepted that she was aware of the requirement for a search to be performed on 22 April 2020, if not by her then by a male CO. It was open to her to request that her supervisor arrange for a male CO to assist with that search or to expressly request/confirm CO Everett did so. This was a significant omission on her part and, to a lesser extent, CO Everett, owing to his lack of experience and junior position relative to CO Welsh.
138. Counsel for CO Welsh submitted that she gave her evidence in a truthful manner, doing her best to recall events from some years ago. I accept that characterisation of her evidence. While she did not recall precisely what went through her head on 22 April 2020 as inmates were moved into the chute, she assumed that the male CO would know to do the pat searches, as this had been her usual experience. Her counsel pointed out that other officers also gave evidence which supported the practice that when male and female officers were rostered together, the male would undertake the pat search. CO Hurlstone gave evidence that it was in his experience an assumption that the male would do the searching. Supervisor Aston also told the court that he would assume a male officer would know that, if rostered with a female, the male would know to do the pat searching, except in an emergency. Governor Taylor gave evidence that he would not necessarily expect a supervisor to remind junior officers about aspects of searching during internal transfers because that would be expected and in accordance with training. He also appeared to accept that it would likely be assumed, rather than discussed, that the male would conduct the pat searching.
139. Counsel for MTC-Broadspectrum properly acknowledged that MTC-Broadspectrum bears responsibility for ensuring: clearly documented procedure is in place; the provision of adequate instruction/training to its employees about complying with that procedure; and maintaining systems that ensure COs' compliance with that procedure. As of April 2020, there was no instruction provided to COs about how to manage a situation where many inmates are being escorted from an accommodation area by two rovers of whom one is male (e.g., requesting a supervisor to assist) or systems to ensure vigilant monitoring of COs compliance with the Search Instruction. I accept CO Welsh's counsel's submission that what occurred on

⁵² Transcript 17.3.2025, Everett, T43.

⁵³ Ibid T18.22.

⁵⁴ Ibid T45-46.

the morning of 22 April 2020 was likely to have been impacted by inadequacies in the documented procedures for searching, inadequacies in training delivered to new officers, and insufficient supervision of inexperienced staff.

140. Further, MTC-Broadspectrum conceded that had a pat down search been carried out, it would have increased the prospects of there being no weapons in holding cell 4 when the violent incident unfolded. However, counsel for MTC-Broadspectrum agreed with counsel assisting's submission that it is not possible to be more definitive in that respect. It cannot be excluded that the possibility that a search, had it been performed, may not have led to the weapon being discovered owing to where it might have been secreted on the person. The same applies with respect to a wand search given the evidence of the limited numbers and issues with their batteries at this time.
141. I have considered all the evidence and find that it is likely that a weapon of the size that appears to have caused injury to Michael is *most likely* to have been discovered had an adequate body search been conducted.

Changes to searching practice and policy since 22 April 2020

142. The Court accepts there was some inconsistency between CSNSW COPP 17.1 and the MTC-Broadspectrum POP 4.05 at the time of Michael's death. Exactly what the impact of that inconsistency was on the incident is less clear. In any event, the Court accepts that significant steps were taken to improve the supervision of inmate-searching upon internal transfer after Michael's death. Mr Everett described the new policies came in "quite hard", with all COs being required to review and sign off on searching procedures and supervisors constantly reminding staff that searching needed to happen.⁵⁵ CO Hurlstone also confirmed that there was a "big focus" by management on the requirement to search inmates on internal transfers following Michael's death.⁵⁶
143. The previous policy inconsistency has been rectified. The current POP, which was amended in May 2020, and the COPP concerning the searching of inmates are now consistent insofar as the relevant POP imposes the same restriction that female COs must not pat search male inmates except in an emergency.
144. CO Welsh's evidence (which was supported by other witnesses) was that wands are used regularly now and are reliable.⁵⁷
145. Both counsel assisting and counsel for MTC-Broadspectrum submitted that following Michael's death, the searching of escorted inmates within the PCC has been more strictly enforced at PCC. This is both in relation to pat searches and the availability and use of wands. I accept that this accurately reflects the evidence before me. However, while I am unable to

⁵⁵ Transcript 17.3.2025, Everett, T41.40-50.

⁵⁶ Transcript 17.3.2025, Hurlstone, T85.18.

⁵⁷ Transcript 17.3.2025, Welsh, T30.

comment on whether this has significantly reduced the problems of weapons at PCC, I accept that the changes reduce the need for a specific recommendation on this issue.

AVL inmates within the Reception Area

PCC Reception Area on 22 April 2020

146. The PCC Reception Area was an area within the PCC that processed incoming and outgoing inmates. Additionally, on the upper floor of the Reception Area building was the AVL suites. Inmates would be held in holding cells within the Reception Area while awaiting their transfer in or out of the PCC, or their AVL appearance.
147. Reception holding cells are not designed for holding inmates for extended periods of time; they are only built for short-term holds for various purposes.⁵⁸
148. The Reception Area was staffed by COs who were rostered on to oversee the area. There were five COs, including one supervisor, rostered on to service the Reception Area on the morning of 22 April 2020. The Reception Area Manager, Aimee Flynn, was physically located in a different building within the PCC, however, she happened to be in the Reception Area when the first violent encounter between Michael and Mr Sheard unfolded.
149. A primary aspect of the Reception COs' role is processing inmates that enter or exit the PCC. That includes inmates leaving the PCC to attend court (for the day) or other correctional centres (on transfer). It also included inmates entering the PCC possibly soon after being remanded to custody or being transferred there from another centre. Inmates that are being received into the PCC are typically held in holding cells within the Reception Area while they are processed.
150. CCTV cameras were positioned in each holding cell. Inside the Reception Processing Area is a U-shaped bench where COs involved in Reception duties are based. CCTV monitors were positioned in that area which displayed each camera footage in a small thumbnail screen. A thumbnail could be clicked on and expanded to full-screen size. The CCTV camera feed was also linked to the main monitoring base within the PCC.

AVL suite

151. Separate to inmates coming through the Reception Area on their way in or out of the PCC were PCC inmates brought to the Reception Area for legal visits or court appearances via AVL.
152. The AVL facilities were in specific AVL suites located on an upper level in the same building and accessed via internal stairs located within the Reception Area.

⁵⁸ Transcript 20.3.2025, Taylor, T317.

153. Some of the holding cells within the Reception Area were reserved for temporary placement of inmates pending use of the AVL suite and their subsequent escort back to their accommodation area: see NCF at [208].
154. The AVL area was specifically managed by AVL-allocated staff. The AVL COs would be responsible for transferring inmates from the holding cells to the AVL suites and back to the holding cells (from where they would later be escorted back to their accommodation area).
155. There appears to have been an overlap in responsibility, as between the Reception COs and AVL COs, in terms of the management and supervision of the inmates while they were in holding cells in the Reception Area. I accept the submissions put on behalf of CO Palavi that the applicable protocols concerning the duties of the Reception Supervisor did not expressly make clear what responsibility he had for the AVL inmates in holding cells compared to the AVL officers. Further, in the absence of clear limits, it follows that the evidence does not support a finding that the Reception Officer or indeed any other particular officer bore a clear responsibility for decisions regarding how many inmates could be safely placed in holding cells at the Reception Area.

Decision-making around cell placement and numbers

156. As of 22 April 2020, there was no specified maximum as regards the number of inmates that could be placed in the holding cells at any one time.
157. The applicable protocols concerning the duties of the Reception COs and Reception Supervisor did not expressly make clear what responsibility these officers have for the AVL inmates in holding cells as compared to AVL officers.
158. Some inmates escorted to the Reception Area might be delivered by the rovers to an AVL CO, with the latter placing the inmates in holding cells allocated for AVL purposes. It appears that could occur without any recourse to the Reception COs or the Reception Supervisor. On other occasions, the inmates might be delivered to a Reception CO who would place them in a cell.
159. CO Welsh said in evidence that the inmates she escorted over from Area 5, which included Michael and Mr Sheard, were delivered to an AVL CO, rather than a Reception CO. There was no requirement for the rovers to notify the Reception Supervisor of the fact these AVL inmates had arrived and been placed into a holding cell.⁵⁹
160. This is important when considering which CO or supervisor bears responsibility for decisions regarding how many inmates could safely be placed in holding cells. It was submitted that this matter should be the subject of a recommendation, an issue which is addressed below.

⁵⁹ Transcript 17.3.2025, Welsh, T28-29.

Numbers of AVL inmates attending the Reception Area

161. COVID-19 restrictions had begun by 22 April 2020. By that date, court appearances in NSW and legal visits were conducted via AVL. I accept that this meant that the demand for AVL in prisons increased and placed some pressure on the system already in place. At the PCC as of 22 April 2020, the only AVL suite was positioned in the Reception building.
162. It was common evidence amongst witnesses that Wednesdays were the busiest days for AVL court appearances (22 April 2020 being a Wednesday).
163. On 22 April 2020, there were approximately 121 inmates placed in holding cells in the Reception Area for AVL access. These inmates were placed in holdings cells 1 to 8 and 10 to 11.
164. On this day, there were also several inmates (approximately 10) who also needed to be separated from certain other inmates for various reasons: see NCF at [228].
165. Cell 4 was typically not used to hold AVL inmates but it was used on this date owing to the unavailability of some of the AVL cells. Three of the AVL holding cells were offline due to maintenance issues. I accept this caused further pressure on the system. An additional cell within the Reception Area had no running water or toilet amenities (only one inmate was permitted to be placed in there).⁶⁰

Cell 4's capacity

166. Cell 4 is approximately 5 metres by 3 metres in dimension.⁶¹
167. It contained one toilet which offered little privacy to an inmate. There was an internal camera positioned in the upper back corner of the cell which was linked to the CCTV monitor in the Reception Area and to the main monitoring area within the PCC.
168. In total, there were 18 inmates (including Michael) in cell 4 on the morning of 22 April 2020 and who were in that cell when the violent encounter first began about 2.5 hours after the inmates were first placed there.⁶²
169. It was clear to the COs present that cell 4 was overcrowded.
170. It is certainly reflected in the CCTV footage which shows a number of inmates standing and pacing in that cell between 9:30am and about 11:30am (when the cell camera was covered).
171. Prior to the commencement of the hearing, I also had the opportunity to attend the PCC and enter cell 4 with less than 18 barristers and solicitors. Even for a short time and in very different circumstances, the cell felt uncomfortably crowded.
172. CO Welsh, who escorted the inmates from Area 5 to the Reception Area, said that on arrival at the Reception Area they were met by an AVL CO. The AVL CO opened cell 4 and directed

⁶⁰ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [13]-[14].

⁶¹ Ibid [11].

⁶² Ibid [16].

the whole group were to be placed in that cell. CO Welsh said she expressed concerns to the AVL CO at overcrowding in the cell. In her statement for the inquest, CO Welsh stated she “told the AVL staff there were way too many inmates to be placed into the one holding cell. The AVL officer responded that that was the only holding cell available. I saw that a number of holding cells were locked off with maintenance workers doing some work in those cells.”⁶³ In her oral evidence, CO Welsh further stated:⁶⁴

“... I can't recall exactly what was said, but I remember looking at the cell and how many inmates I had, and that it was just, it was too small to have all the inmates that we had in there. And I remember them saying that that's all they had available at the time.

...

I just knew how many we had compared to the cell size. It was just way too many to have in there. That's just from experience”.

173. CO Welsh's evidence about this was consistent with that given by several COs that were present on that day and who gave evidence in these proceedings.

Risks posed by overcrowding

174. Overcrowding of a cell created the following risks:
- i. There being very little area for an inmate to retreat or to avoid an incident.
 - ii. A greater risk of frustration and agitation amongst the inmates.
 - iii. A heightened risk of danger of COs entering the cell during an incident.
175. This is separate to the risks to physical safety and ensuring conditions are humane.

Findings regarding the numbers in cell 4 on 22 April 2020

176. Taking all the available evidence into account, counsel assisting submitted that there were a number of available findings as regards the numbers in cell 4 on 22 April 2020.
177. *First*, counsel assisting submitted that there were far too many inmates confined in cell 4. It was submitted that the numbers of inmates in that small environment posed significant risks to the inmates' safety. That risk was significantly compounded by virtue of inmates within that cell having gaol-made weapons on their person. Some alternative arrangement should have been effected to lower the numbers in any one cell, even if that meant inmates were not immediately available to appear on AVL as required (e.g., if they were sent back to their Accommodation Area until sufficient space was available). Counsel for MTC-Broadspectrum agreed that there were too many inmates confined to cell 4 and that the number in that small environment posed significant risks to inmates' safety. It was further conceded that alternative arrangements should have been made to lower the numbers, however, there were difficulties involved in making inmates available for court AVLs. I am comfortable in finding that there were too many inmates in cell 4 on 22 April 2020 at the time of Michael's death. This should have been identified and alternative arrangements should have been made.

⁶³ Statement of Tori Welsh dated 10.3.2025: Vol 1, Tab 66B, [13].
⁶⁴ Transcript 17.3.2025, Welsh, T27-28.

178. *Second*, it was submitted that MTC-Broadspectrum, as with most (if not all) operators of correctional centres in NSW, were experiencing an exponential increase in demand for inmate AVL access. This increase was in large part owing to the COVID-19 pandemic, which resulted in a cessation of visits to prisons and vacating of physical appearances in court, including for persons in custody. This was not disputed by MTC-Broadspectrum. I accept that this was a relevant factor in the overcrowding which occurred.
179. *Third*, it was submitted that a tension arose between the issue of overcrowded cells in the Reception Area, which was evident to officers and supervisors in that area, and MTC-Broadspectrum's obligation to ensure inmates were available for AVL appearances as required by the courts. This was not disputed by MTC-Broadspectrum. I accept that this was a relevant factor in the decision-making on 22 April 2020 and that COs were not provided with guidance about how to deal with this tension.
180. *Fourth*, it was submitted that there were no express limits on the number of inmates that could be placed in holding cells, including holding cell 4. This was significant given the numbers that were ultimately placed in there. This was accepted by MTC-Broadspectrum. In my view, there should have been a clear limit to assist officers in managing the situation on 22 April 2020.
181. *Fifth*, it was submitted that the overcrowding was compounded by three holding cells being offline. This was not disputed by MTC-Broadspectrum. This was clearly a factor in how events played out on the day of Michael's death.
182. *Lastly*, it was submitted that MTC-Broadspectrum did not expressly require the COs, Supervisors, or Managers in the Reception Area (whether there in the capacity of Reception or AVL) to limit the numbers of inmates placed in holding cells for safety reasons or to be vigilant in avoiding overcrowding. Nor did it provide practical instruction or training to staff working in these areas about how to manage situations of this kind. This was accepted by MTC-Broadspectrum and it supported a recommendation aimed at providing guidance to COs working in the Reception Area in relation to the number of inmates held in the area to prevent unsafe numbers in these cells. In my view, it is an appropriate matter for a recommendation.

Specification of cell limits

183. In July 2020, a risk assessment worksheet was completed and identified the safe capacity in cell 4 being a maximum of 10 inmates.⁶⁵
184. However, as of March 2025, when the hearing took place, the limit for cell 4 was specified as 14 inmates.⁶⁶

⁶⁵ Risk Assessment Worksheet: Vol 5, Tab 218, p. 2.

⁶⁶ On a view of the PCC by the counsel assisting team and legal representatives of interested parties, a plaque could be seen on the door to cell 4 indicating a maximum inmate number of 14.

185. Governor Taylor gave evidence regarding how the current limit was determined.⁶⁷ He reviewed cell limits in the Reception Area about three months after he commenced as Governor at the PCC (which was in about September/October 2023).
186. To determine cell capacity, he said that he and others “*all sat down on the benches, and we thought everyone should get a seat, and if there was enough seats in the yard for those people then we classified it as that’s the number*”.⁶⁸
187. When considering the maximum number of inmates in a cell, Governor Taylor’s evidence was:
- “We did it because we wanted to ensure that we were capable of managing those inmates. We wanted to actually communicate with the inmates so the inmates knew that the rationale why we did that, made that decision, and the other reason was because if we numbered and we categorised the yards in such a way, it allowed me to have an informed opinion where the infrastructure was capable of managing the demands of that facility or did I need to go back and have negotiations with the State in regards to the sum of the – with the increase of AVL, for example, was the capacity of the prison or the infrastructure capacity not matched with ... what was being asked for us to deliver under the contract. So that’s how we fell on those numbers”.*⁶⁹
188. Governor Taylor considered that 14 AVL inmates in cell 4 was not an “*unruly or unmanageable*” number.⁷⁰
189. Counsel assisting cautioned against accepting Governor Taylor’s opinion in this respect, noting the following factors
- 14 is a significant number of inmates given the dimensions of the cell (about five by three metres), and the risks that poses for boredom, agitation, and violence with those numbers in the cell even for short periods (e.g. a couple of hours).
 - It does not appear Governor Taylor, or MTC itself, has examined how the cell limit of 10 inmates was arrived at in July 2020. At the very least, there is no evidence in this inquest that the basis upon which that maximum limit was reached was unreasonable or less cogent as compared to the method adopted by Governor Taylor (described above).
 - It is not clear on the evidence whether 14 inmates in cell 4, as compared to 10 inmates, would materially impact the capacity of the IRT to enter that cell if required to extract a violent or injured inmate. That should also be examined in determining safe cell limits.
190. The matter was given full consideration by MTC-Broadspectrum. On reflection, MTC-Broadspectrum conceded that 14 is a large number of inmates for cell 4 for any extended period of time and it was accepted that the cell limit of 10 which had been arrived at in July 2020 was not unreasonable. However, it was noted that even if the limit had been 10, this

⁶⁷ Transcript 20.3.2025, Taylor, T315-316.

⁶⁸ Ibid T307.

⁶⁹ Ibid T318.

⁷⁰ Ibid T317.

would not have materially impacted the capacity of the IRT to safely enter that cell in the kind of circumstances which existed on 22 April 2020.

191. MTC-Broadspectrum supported counsel assisting's draft recommendation which called for a review on the limits on the maximum number of inmates that can safely be held in the PCC's Reception Area. MTC-Broadspectrum informed the Court that it will involve its on-site Manager of Security, Safety, and Wellbeing specialist (WHS) under the direction of the Governor in any such review. I intend to make the draft recommendation.
192. The Court also notes that the PCC has enhanced its AVL facilities since Michael's death. Other AVL holding cells and suites have been built within (or closer to) residential areas of the gaol, whereby reducing the number of inmates that need to be held in cells in the Reception Area. This is a positive change and one which reflects a permanent change in relation to the use of AVL systems within the justice sector.

What happened at the Reception Holding Area

193. The NCF document outlines in detail the events which occurred in cell 4 at [216] and [229]-[291].

Placement of the AVL inmates in cell 4 at about 9:30am

194. Michael, Mr Sheard, and other inmates had been escorted from Area 5 of the PCC and were placed in cell 4 with about 16 other inmates in the Reception Area at about 9:40am to await court appearances via AVL.
195. One of the inmates, Luke Welford, was taken from cell 4 that morning and provided Suboxone wafer, which was administered to him by medical staff pursuant to a prescription. He then returned to cell 4 and was locked back in with the other inmates.
196. On his return, Mr Welford diverted his Suboxone in the cell by removing it from his mouth.

Supervisor Palavi identified Mr Sheard in the cell before the first violent exchange

197. Supervisor David Palavi was rostered onto the Reception Area on the morning of 22 April 2020. He recalled that on that morning, an inmate in cell 4 came to his attention because he was wearing non-gaol-issued Nike shoes.
198. Supervisor Palavi overheard inmates calling the man in the Nike shoes Emmett Sheard so he looked on the OIMS system and noted that the Nike shoes were not on Mr Sheard's property card. Based on this information, Supervisor Palavi formed the intention to remove Mr Sheard from the cell to perform a strip search with the Reception staff and then confiscate the shoes.

199. Supervisor Palavi then ran an Incident Report Module through OIMS to check if Mr Sheard was a violent inmate and noticed that he was involved in numerous violent activities in the preceding 12 months, many of which involved contraband and weapons.⁷¹
200. Supervisor Palavi considered it a safety risk to remove Mr Sheard from the cell for such a search. Supervisor Palavi then tried to phone the IRT to have them attend Reception and search Mr Sheard when he was removed from the cell for his AVL appearance. He was not able to get through to the IRT. The first violent exchange in cell 4 commenced sometime after that call. I accept the submission that Supervisor Palavi acted appropriately once he became aware of the Nike shoe issue, including identifying the need to contact the IRT.

Covering of the cell 4 camera at about 11:30am

201. At around 11:30am, one of the inmates in cell 4, Mr Harris, covered the CCTV camera in cell 4 by throwing wet toilet paper over it. This appears to be a tried and true mechanism used by inmates to avoid surveillance.
202. The camera in cell 4 was not a “smart camera” in that it did not automatically provide an alert to the monitors if it was covered (although it did provide for an alert to the PCC master control room).⁷² This camera remained covered for about 40 minutes (during which both the first and second violent incidents occurred).
203. It was common evidence amongst Reception Area staff that as of 22 April 2020 they would glance or look at the CCTV monitor screens if they were walking past but generally would not proactively monitor the screens. The frequency with which a staff member would look at the screen would depend on how busy they were doing their other duties.
204. I accept the evidence before me that the period around 11:30am was busy, with staff engaged in transferring inmates from a truck and processing inmates in relation to outgoing orders.

Workload in the Reception Area at about 11:30am

205. At about the time the cell 4 camera was covered (11:30am), a truck arrived at the Reception Area with 15 inmates to be transferred into the Centre. At around this time, there were also 14 inmates being transferred out of the Centre who had been waiting in a holding cell. This was an especially busy period in the Reception Area that day.
206. Both the workload in the Reception Area and the covering of the camera materially limited the supervision provided to the inmates within cell 4 after 11:30am.
207. The covering of the camera, and when that fact was realised, is significant to the events that followed as it impacted the supervision of what was occurring. It also meant that objective evidence (footage) of the fatal stabbing was not obtained.

⁷¹ Transcript 20.3.2025, Palavi, T354.

⁷² Transcript 20.3.2025, Taylor, T316.

When did the Reception staff realise the camera had been covered?

208. There was some ambiguity about when COs became aware that the CCTV camera had been covered, namely:
- i. CO Shellie Brown gave evidence that it was likely before the second violent exchange between Michael and Mr Sheard had occurred that she became aware the camera was covered, “*because when the first incident happened the CCTV would have been reviewed then.*”⁷³ She could not recall anyone mentioning that the camera had been covered before the first violent exchange in cell 4. CO Brown agreed that it was possible (but could not say for sure) that someone did know that the camera was covered, but there was nothing anyone could do.
 - ii. IRT member Benny Fiso gave evidence that when the IRT attended cell 4 in response to the first violence exchange, CO Nathan Attard told him that the camera was covered.⁷⁴ CO Attard disputed this in his evidence saying that he was “*pretty sure*” he would not have seen that the camera was covered in the first place.⁷⁵
 - iii. IRT member Nathan Schwenke gave evidence that after the first violence exchange when they were moving into the Reception Area, CO Attard said that the camera cell had been covered.⁷⁶ He then accepted that his memory was bad and that it was just “*at some stage*” they were told the camera was covered.
209. I accept that given the state of the evidence it is not possible to positively find that any CO (e.g., CO Attard) realised that the camera was covered before the first violent encounter unfolded.
210. It then follows that forty minutes may have passed during which its covering had gone undetected, being the time between when it was covered and the first violent encounter.
211. This underscores the limits of the supervision the Reception COs and Supervisor were able to provide in that period.
212. There is no evidence to suggest that the COs were not otherwise engaged in duties or had reasonable capacity to check the CCTV monitors.
213. The lack of monitoring of the CCTV monitors stemmed from a lack of capacity owing to competing demands.

⁷³ Transcript 17.3.2025, Brown, T97.

⁷⁴ Transcript 18.3.2025, Fiso, T187.

⁷⁵ Transcript 18.3.2025, Attard, T117.

⁷⁶ Transcript 18.3.2025, Schwenke, T170.

How staff might have responded had the covering of the camera been realised

214. Counsel assisting submitted that even if it is assumed that it was known before the first violent encounter that the camera had been covered, it is doubtful that this could have been reasonably rectified before the second incident.
215. At the hearing, it was common evidence amongst PCC staff that inmates regularly cover CCTV cameras. It was considered unsafe for a CO to enter a cell like cell 4, with the number of inmates it held on 22 April 2020, to remove whatever was covering a camera.
216. Unless the inmates were persuaded to remove the paper themselves, it would have been necessary to clear all inmates out of that cell before a CO could enter to do so. This would require the placement of those inmates in another cell while that occurred.
217. Given the limited cell availability on this date, I accept that it is difficult to conceive how that option would have been a reasonably practical one, at least before the violent encounter unfolded.

Changes to CCTV monitoring after 22 April 2020

218. After the incident, practice regarding the monitoring of CCTV cameras changed whereby extra checks were required to be done and monitoring is now logged.⁷⁷
219. On about 15 May 2020, MTC-Broadspectrum notified the Department of Communities and Justice of remedial action undertaken by the former following Michael's death.⁷⁸ That remedial work included the installation of "*CCTV technology that sends an alert when a camera is covered was considered and was installed within 3 months of the incident. It is still in effect*".
220. In a statement completed for this inquest on 21 March 2025, Jeremiah Peteru, Manager of Security at the PCC, stated that MTC-Broadspectrum had special software installed for CCTV cameras in the Reception/Intake Holding Area, including in cell 4. If an object such as toilet paper, a sticker, or a book, is placed in front of the CCTV lens and blocks the view, the camera triggers a non-audible but flashing alarm that is sent to the PCC's base.⁷⁹ The alarm is not sent to the CCTV monitors located within the Reception Area.⁸⁰ However, staff in the PCC's base are expected to immediately notify staff in the Reception Area if an alarm is activated.⁸¹
221. While this appears to be an improvement, I am unable to comment on the level of monitoring that occurs at the PCC's base as no evidence on this issue was provided.

Response of COs and the IRT to the violent encounters in cell 4

222. At around 12:00pm on 22 April 2020, a dispute arose in the cell concerning the Suboxone wafer that Mr Welford had diverted and that flowed into a violent incident between Michael

⁷⁷ Transcript 17.3.2025, Brown, T99.

⁷⁸ MTC-Broadspectrum provided a schedule of remedial works following issuance of a "Notice of Major Default – Death in Custody" issued to it by the Department of Communities and Justice on 1 May 2020 (Exhibit 9).

⁷⁹ Statement of Jeremiah Peteru dated 21.3.2025 (Exhibit 7).

⁸⁰ See evidence of Governor Taylor: Transcript 17.3.2025, Taylor, T316-317.

⁸¹ Statement of Jeremiah Peteru dated 21.3.2025 (Exhibit 7).

and Mr Sheard shortly before 12:10pm. I am unable to make specific findings as to what occurred shortly before or during this first violent encounter.

223. COs within the Reception Area were alerted to noise coming from cell 4 and attended. By the time the COs attended, the violent exchange had ceased, but Mr Sheard came to the attention of the officers as one of the inmates involved. He was seen with an injury to his eye and presented in an agitated manner, refusing requests to exit the cell to be assessed at the clinic. Mr Sheard was identified as having distinctive white Nike shoes.
224. The COs had made a Centre Emergency Response Team call which alerted IRT members who were situated in a separate area to the Reception. The IRT arrived at the Reception Area about 12:12pm and initially spoke with CO Attard.
225. The IRT members requested Mr Sheard exit the cell, which he refused to do. No weapons were seen by the COs or IRT at this time.
226. At around 12:13pm to 12:15pm, the IRT members and other Reception COs made their way into the Processing Area which was across the corridor from cell 4.
227. Soon after the COs and IRT had entered the Processing Area, a second violent exchange unfolded in cell 4 between Mr Sheard and Michael. This exchange was underway by 12:16pm.
228. One of the IRT members, CO Hawthorne, saw Mr Sheard stand up and strike Michael. He saw Michael return punches at Mr Sheard.
229. During this exchange, Mr Sheard inflicted stab wounds to Michael with a gaol-made weapon (shiv).
230. Michael retreated into the front right-hand corner of the cell and stood up on one of the benches and could be seen bleeding. He kicked out at Mr Sheard.
231. The COs and IRT members made their way back to the corridor out the front of cell 4. The infliction of stab wounds to Michael had occurred by the point the IRT members and COs exited the Processing Area into the corridor (directly in front of cell 4).
232. Mr Sheard was filmed standing in the centre of the cell holding the shiv and acting in an agitated and aggressive manner towards Michael. Mr Sheard was ordered to drop his weapon, but he did not comply. At one point, he went to the back of the cell then returned shortly after, no longer holding the weapon.
233. Michael asked to be let out of the cell. He managed to get off the bench and move on his backside towards the cell door that IRT member CO Fiso had opened. Michael was dragged out and the medical response commenced.

Findings as to what immediately preceded the infliction of the fatal stab wounds

234. Counsel assisting submitted, and I accept, that there are limitations in the evidence which impact the findings that I can comfortably make as to what occurred just before the fatal wounds were inflicted. These include:
- There was no CCTV or body-worn video (**BWV**) that captured the violent physical encounters including what was happening when the fatal stab wounds were inflicted.
 - Only one eye-witness inmate from the cell provided a statement, but his credibility was significantly impugned during the criminal trial.
 - Mr Sheard gave evidence at trial. His case was that he acted in self-defence. He was acquitted on that basis. Care must be taken to avoid putting into doubt the incontrovertibility of that acquittal.
 - There were inconsistencies in the evidence of COs about what they witnessed during the start, or portions, of the second violent exchange in the cell.⁸²
 - There is, for obvious reasons, the inability to receive Michael's account of what unfolded owing to his death.
235. Having reviewed the evidence, I am nevertheless satisfied that Mr Sheard inflicted the fatal injuries to Michael using a gaol-made weapon. Michael likely had hold of a gaol-made weapon at some point before he was removed from the cell by IRT members. This was dropped or fell to the ground as he was removed from the cell.
236. Mr Sheard gave evidence in the trial that Michael struck out at him with that weapon and caused him lacerations, which triggered his response in self-defence. His evidence about this must be considered in the context of the other evidence including the aggression he was seen exhibiting before and after Michael's stabbing and the observations of IRT member CO Hawthorne of seeing Mr Sheard stand up and commence throwing punches at Michael (see NCF at [279]-[280]).
237. Accepting the jury was unable to negative self-defence beyond reasonable doubt, this does not mean the jury necessarily accepted Mr Sheard's evidence as to how he suffered the injuries he had when he was removed from the cell.
238. In accordance with the submissions of counsel assisting, supported by submissions made by MTC-Broadspectrum, I am not able to make positive findings as to what exactly happened immediately before the fatal stabbing to Michael (e.g., whether Michael was stabbed after he acted violently towards Mr Sheard or whether Mr Sheard was the primary aggressor immediately beforehand).

⁸²

There is no suggestion that any CO intentionally misstated evidence, but rather the second violent exchange took place very quickly while none of the witnesses were standing directly outside the cell at the time that it started.

Adequacy of the response of the COs and the IRT

239. Evidence regarding the movement of the COs and IRT members and their responses on 22 April 2020 is detailed in the NCF at [246]-[277].
240. It was not unreasonable for IRT members not to enter cell 4 when they initially attended (to remove Mr Sheard) after he refused numerous requests to exit the cell. He was agitated at the time and there were a large number of inmates in the cell (which itself was a problem). I have no trouble accepting that the IRT members faced the risk of being overwhelmed if they entered the cell at that stage.
241. Area Manager Flynn returned to Area 3 soon after the IRT's arrival. She said that upon attendance at a situation by the IRT, it was standard practice for COs to handover the situation over to the IRT.⁸³ Supervisor Wise Lagilevu was the lead officer in the IRT.
242. Soon after, the remaining COs and IRT members who were in the corridor close to cell 4's door moved back into the Reception Processing Area. Supervisor Lagilevu did not direct any of the COs to remain outside the cell.
243. IRT member CO Hawthorne said he understood the rationale for entering the Reception Processing Area was that it was best practice for the IRT to move to an area out of ear shot of the inmates to plan a response. CO Hawthorne said he was about five metres inside the door of the Reception Area keeping an eye on cell 4.⁸⁴ CO Hawthorne also said "*one of our tactical options is physical presence where it may you know help the situation stop, but doesn't mean it will. It's just one of the options.*"⁸⁵
244. IRT member CO Fiso said he moved into the Reception Processing Area to arrange medical treatment for Mr Sheard as he was refusing to exit the cell.⁸⁶ His evidence as to the rationale differs to that of IRT member CO Hawthorne. He accepted that, in hindsight, someone should have remained in the corridor near cell 4 in direct sight of the cell.⁸⁷
245. CO Attard said that after he moved into the Reception Processing Area he stayed towards the front door, about one to two metres behind it, so that he could "*keep eyes on the cell*".⁸⁸ CO Attard said "*Well, you show some presence and usually they will disengage because they don't want to be charged internally and stuff...*"⁸⁹
246. IRT member CO Hawthorne was the only CO that appears to have had a continuous line of sight of cell 4 when the second altercation began. He witnessed Mr Sheard stand up from the bench in a staunch fighting-like stance. He saw Mr Sheard appearing to throw punches at

⁸³ Transcript 18.3.2025, Flynn, T134.

⁸⁴ Transcript 18.3.2025, Hawthorne, T152.

⁸⁵ Transcript 18.3.2025, Hawthorne, T149.

⁸⁶ Transcript 18.3.2025, Fiso, T183.

⁸⁷ Transcript 18.3.2025, Fiso, T189.

⁸⁸ Transcript 17.3.2025, Attard, T119.

⁸⁹ Transcript 17.3.2025, Attard, T116.

Michael. The other COs and IRT members either did not have a continuous line of sight or were unable to see what was unfolding in cell 4 from their position.

247. I am comfortably satisfied that it would have been prudent for one or more COs or IRT members to have remained directly outside cell 4. I note that Supervisor Lagilevu conceded that while it was appropriate to move away to plan a response, with hindsight it may have been prudent for one or more COs to have remained directly outside cell 4 in the hope it may have had a “*tempering influence*” on inmate behaviour. The inmates’ awareness of the COs’ immediate presence, and that they were being closely observed, may have lessened the chances of the second violent encounter ensuing. It also would have meant that correctional staff were better placed to give direct eyewitness accounts about what was happening when the fatal stab wounds were inflicted. However, I accept MTC-Broadspectrum’s submission that it is possible that remaining directly outside may not have prevented the second violent encounter.
248. Counsel assisting submitted that there would be benefit in MTC reviewing the training it gives IRT members in responding to incidents of this kind, with a view to using this case as a scenario in the training/instruction of members. This may be of use in other COs’ response if similar events arise. A draft recommendation was proposed which is aimed at reviewing the training and instruction of IRT members using any lessons which might be drawn from this incident. While the recommendation was partially accepted by MTC-Broadspectrum, it was noted that the primary training of IRT members is conducted externally by Corrective Services Security Operations Group. MTC is concerned not to contradict anything taught in primary training. I intend to make a recommendation taking into account these submissions.

Lack of use of IRT body worn cameras

249. When the IRT first attended the Reception Area, none of the members had their BWV turned on. CO Schwenke explained “*So if we respond to an incident, we’re supposed to turn it [BWV] on, obviously so it can capture the incident, but I think upon arrival to reception we were told that it had ceased fighting, so I never activated my camera, so there was no real incident to record*”.⁹⁰ Counsel assisting and MTC-Broadspectrum submitted that I would not make adverse findings against these COs in this respect. I accept that it is appropriate not to make adverse findings against any individual CO in this instance, although COs should be encouraged to err on the side of caution in situations which may be volatile or have a potential to re-ignite.

Serious Investigation Report

250. MTC-Broadspectrum was issued a notice of contravention and required to report on remedial steps it was taking in response to Michael’s death, which it did.

⁹⁰ Transcript 18.3.2025, Schwenke, T164.

251. Separate to the notice of contravention, CSNSW completed a Serious Incident Report into Michael's death. This was completed on 26 July 2021. This report outlined the author's opinions as to potential contraventions of CSNSW COPPs and related *Crimes (Administration of Sentences) Regulation 2014*: see NCF at [334]-[335].⁹¹
252. One of the issues explored in the hearing was what part(s) of that report, if any, were provided to MTC-Broadspectrum for its consideration. On the evidence, it is not certain what part, if any, of that report was communicated to MTC-Broadspectrum.
253. It appears there is no requirement that CSNSW provide these reports to a private operator like MTC-Broadspectrum, although the reports' findings may be relevant to the operator's management and response to a critical incident. Counsel assisting submitted that it may be beneficial for an operator such as MTC to receive reports of this kind in future as it may assist it in identifying deficiencies in its practices and implementing improvements. Counsel for both CSNSW and MTC-Broadspectrum agreed.
254. I intend to make the draft recommendation provided by counsel assisting directed to this issue.

Michael's access to medical treatment at the PCC

Michael's background

255. The following summary is drawn from the background set out in the NCF at [90]-[130] and [161]-[186].
256. Michael first entered adult custody in July 2005. He served several periods in custody, either on remand and/or as a sentenced prisoner, between 2005 and 2020.
257. Some convictions (before February 2020) related to substance abuse, which commenced in his mid to late teens and continued through adulthood. Michael also had a history of substance-related misconduct offences in custody, incurring nine separate "fail prescribed drug test" offences and two "possess drug implement offences" between March 2006 and June 2019.
258. As a condition of his parole in late 2019, Michael reported to and engaged with Community Corrections in Wollongong.
259. During his meetings with Community Corrections up until February 2020, Michael reported that he was regularly using unprescribed buprenorphine.
260. As a result, Michael was referred to and underwent an assessment at the Denison St Clinic⁹² in Wollongong in December 2019/January 2020. Denison St Clinic was a private methadone and opioid substitution clinic.

⁹¹ Regarding the finding that the Reception COs and Supervisor had contravened procedure and CAS Regulation by failing to notice the covering of the cell 4 camera, the difficulty is that the relevant procedure did not require continuous monitoring of the CCTV monitor. Nor was that realistically possible given the workload the officers had at the relevant time.

⁹² Denison Street Clinic has since closed down.

261. Michael was assessed suitable for buprenorphine therapy at the Denison St Clinic on or by 23 January 2020. On that date, the NSW Pharmaceutical Regulatory Unit (**PRU**) issued an approval that permitted the prescription of buprenorphine by that clinic to Michael for this purpose.
262. Ultimately, for reasons that are not known, Michael did not attend the clinic to commence his therapy and for that reason he was exited from the therapy program on 5 February 2020.
263. On 11 February 2020, while reporting to Community Corrections, Michael disclosed having used buprenorphine and that he was using around half a “strip” a day: NCF at [109].
264. In late February 2020, Michael was charged with new alleged offences in the community from January and February 2020. The State Parole Authority also revoked his parole and he entered the Amber Laurel Correctional Centre.
265. On 28 February 2020, Michael transferred to the PCC.

Whether Michael had dependence on opioids at the time he entered the PCC on 28 February 2020

266. I am satisfied that Michael met the criteria for a diagnosis of opioid dependence as of January/February 2020. That finding takes into account Michael’s reports to Community Corrections in late 2019/early 2020 about his illicit substance use, the fact of him being approved by the PRU to receive opioid replacement therapy (**ORT**) (or opioid substitution therapy (**OST**)) (buprenorphine) in January 2020 (which was dependent on a qualified practitioner making that diagnosis), and the evidence given by Professor Lintzeris on this matter.⁹³ Counsel for SVCH appropriately conceded that it is likely that Michael met the relevant criteria for a diagnosis of opioid dependence in January and February 2020, noting of course that SVCH was not aware of all the relevant information at the time of his admission to the PCC.
267. Professor Lintzeris described the nature of opioid dependence not necessarily meaning “active” dependence and explained that it may capture more nuanced scenarios, stating in his oral evidence:

“...a diagnosis of opioid dependence is a diagnosis which actually is a kind of broad diagnosis in that someone does not actually have to actively be using opioids to still have a diagnosis of opioid dependence. Someone can have opioid dependence in remission, which means they have not used opioids in the preceding one month if you use ICT 10 or 11 classification, or preceding three months if you want to use a DSM-5. So the different classification systems have different periods in which they will allow you to say this patient is still opioid dependent but they are in remission as opposed to they have an active opioid dependence which implies more recent use. When it comes to an indication for buprenorphine treatment, we generally are comfortable with the diagnosis of opioid dependence, does not necessarily mean that they have active dependence. It may be in remission.”⁹⁴

⁹³ Transcript 21.3.2025, Professor Lintzeris, T427-428.
⁹⁴ Ibid T428-429.

Relevance of Michael's substance use to the events on 22 April 2020

268. The evidence shows that while at the PCC Michael made several requests to be assessed for the Suboxone Program (also known as Opioid Treatment Program or **OTP**). As of 22 April 2020, that assessment had yet to take place.
269. The catalyst of the violent exchanges on 22 April 2020 appears to have been Michael's attempt to obtain Mr Welford's diverted Suboxone. There is little doubt that prisoners who are untreated for substance use issues may be at particular risk of becoming involved in gaol violence.
270. It was, therefore, necessary as part of this inquest to ascertain what Michael's opioid use in custody was as of 22 April 2020 and determine whether he had reasonable access to being assessed for the OTP provided by SVCH.

Opioid replacement therapy at the PCC

271. Evidence about OST in custody, including policies and procedures, is outlined in the NCF at [131]-[155].
272. SVCH was not subject to Justice Health ORT "capping" of the number of inmates on ORT in 2020.⁹⁵ No cap existed at the PCC as of February 2020.⁹⁶
273. Since 2020, there has been a rollout across correctional centres in NSW of injectable buprenorphine which has essentially, over time, replaced Suboxone film. The advantage of the injection as compared to the Suboxone film is that there is less opportunity for diversion.⁹⁷

Initial reception and assessment on reception

274. Upon his reception to the PCC on 28 February 2020, Michael underwent reception screening with Registered Nurse (**RN**) Bastola, who was employed with SVCH. The information recorded in the reception screening assessment (**RSA**) is set out in the NCF at [121] and included, *inter alia*, that:
- i. Michael had been taking half a strip of non-prescribed Suboxone weekly (in the community before entry into custody).
 - ii. Michael denied having used heroin or other opioids (prescribed or otherwise) in the four weeks before his incarceration.
 - iii. Michael reported not being currently on OST.
275. This information is inconsistent with what was known about his buprenorphine use in the community. His reason for making the statements he did during the RSA is not known, but I accept it had an impact on the treatment he received.

⁹⁵ As at February 2020, there was a Justice Health cap of 700-800 inmates who could be receiving ORT. This cap no longer exists and there is currently close to 2,500 inmates across NSW receiving ORT in correctional centres.

⁹⁶ Transcript 21.3.2025, Johnston, T391.

⁹⁷ Transcript 21.3.2025, Cooper, T374

276. Following the completion of the RSA, the reception screening nurse entered Michael on waitlists to be reviewed by a Drug and Alcohol Nurse, Mental Health Nurse, and Primary Health Nurse. Kirsty Johnston gave detailed evidence in relation to the process of waitlisting patients in a correctional centre primarily consisting of remand prisoners. She told the Court that there were three relevant priority ratings, with patients placed in the following categories: urgent – to be seen within 48 hours; semi-urgent – to be seen within 2-14 days; and non-urgent – to be seen within 14-90 days. She advised that the waitlists are continually moving, with patients at times being triaged and re-triaged depending on developing needs. Counsel for SVCH explained that given the waitlist travels with the custodial patient between correctional facilities, the PCC can gain patients with significant waitlists from other centres.
277. A request was also made to the Illawarra Medical Services (a GP practice) regarding Michael’s “medication and surgical history”. The information provided in response to this request concerned Michael’s treatment in hospital for a broken leg in December 2019 and contained no reference of the Denison St Clinic assessment. I accept that the Denison St records were not obtained because it appears Michael did not mention that consultation to RN Bastola.
278. As at February 2020, SVCH was able to source information from the PRU as to whether persons had been authorised to be prescribed OTP medications (SVCH’s access to the SafeScript system did not occur until after February 2020).⁹⁸ SVCH made no inquiry with the PRU following reception. This likely owed to Michael’s statement, during reception, that he was not currently on OST.
279. The fact that Michael had been recently approved for OTP medication before his return to custody was not known to the SVCH before his death.

Referrals for reviews

280. The reception screening nurse entered Michael on waitlists to be reviewed by the:⁹⁹
- i. Drug and Alcohol (**DOA**) Nurse (Priority 2 – Semi Urgent);
 - ii. Mental Health Nurse (Priority 3 – Non Urgent); and
 - iii. Primary Health Nurse (Priority 4 – routine).
281. On 2 March 2020, Michael’s scheduled DOA review was cancelled owing to a more urgent priority. As a result, Michael remained on the waitlist pending the availability of the DOA clinical nurse to conduct a review subject to other patients and their prioritisation. On this date, the DOA clinical nurse also amended the triage priority for Michael’s review to a “Priority 3 – Non Urgent”: NCF at [156].

⁹⁸ Ms Johnston confirmed that SVCH staff now have access to SafeScript NSW: Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A, p. 11 [65].

⁹⁹ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A, p. 5 [27]-[31].

282. Kirsty Johnston described what she thought would have occurred at this time: “so *the* [DOA] *specialist would have reviewed the reception screening and the patients file and then based on the information that had been received from the patient in the reception screening he then would have made a clinical decision as to the priority to see him.*”¹⁰⁰
283. It is possible that this decision was made on the basis of the information recorded in the RSA, namely that outside the report of taking half a strip of Suboxone weekly, Michael denied any other illicit substance or medication use before entering custody. The effect of the change in priority was that the priority assigned to carrying out a DOA review of Michael was lessened as compared to the priority assigned at the time of reception.

Removal of Michael from the DOA waitlist on 10 March 2020

284. After the hearing of the inquest concluded, Justice Health provided those assisting me with PAS records which indicated that Michael had been removed from the DOA waitlist on 10 March 2020 and that he was not placed back on the DOA waitlist until 8 April 2020 (with an appointment scheduled for 15 April 2020).¹⁰¹ SVCH indicated that there is no record outlining the rationale for Michael’s removal from the DOA waitlist. SVCH has apologised that Michael was taken off the DOA waitlist, conceding that had he remained on the DOA waitlist prior to 8 April 2020, an appointment may have been booked prior to 15 April 2020.
285. I find Michael’s removal from the waitlist extremely troubling, especially in circumstances where I am unable to assess the reasoning behind this decision. In my view, taking Michael off the waitlist and thereby removing his chance of being assessed as suitable for ORT in a more timely manner had the capacity to increase the danger of his incarceration.

Requests to commence OTP and medical review for other complaints

286. On 12 March 2020, Michael was seen by MTC-Broadspectrum psychologist Andrew Redden. In Mr Redden’s view, Michael’s primary concern at that time was his wish to commence the ORT. Michael advised that he had already been referred for assessment by the SVCH for inclusion in that program. Mr Redden noted that motivation during the assessment was being included on the OTP: NCF at [160].
287. Thereafter, Michael made several requests to be assessed for ORT and requested assistance with other health issues (e.g., pain). That was done through self-referral forms between 15 March and 8 April 2020. These requests are outlined in the NCF at [157]-[160], [163]-[168], [172], and [177].

¹⁰⁰ Transcript 21.3.2025, Johnston, T 398.

¹⁰¹ Exhibit 12.

288. This included his report on 8 April 2020 that he had been on “*the bupe or methadone program...on the outside*”, he was concerned his pain might result in him “*killing someone*” if he was not addressed, and his statement that “*I need help URGENT*”: NCF at [177].
289. A DOA review scheduled to take place on 15 April 2020 did not occur likely owing to Michael not being brought to the clinic for the assessment (the reasons for that are not known): NCF [178]. Counsel for SVCH submitted that this appointment was “cancelled” by COs for reasons not known. Ms Johnston gave evidence that the PAS entry for this appointment indicated that the appointment was “*cancelled by DCS*” which is “*the only option in the dropdowns [on PAS] that’s related to the [COs]*”.¹⁰² MTC-Broadspectrum submitted that I would not accept SVCH’s submission on this point in circumstances where Governor Taylor gave evidence that COs do not (and are unable to) “cancel” medical appointments.¹⁰³ After reviewing all the evidence on this issue, I was not satisfied that I could make a firm finding about exactly who cancelled the appointment or why it was cancelled. It may be that for reasons we cannot now identify, Michael was not brought to the clinic for his appointment and it was marked “*cancelled by DCS*”. There may be other explanations. Whatever the case, it would appear that SVCH had an obligation to follow this up, rather than accept the appointment was “*cancelled by DCS*”.
290. On the issue of encouraging inmate attendance at medical appointments, the Court was told there is now a procedure whereby nurses can report inmate non-attendance to COs and escalate non-attendance to SVCH management, which is then further escalated to MTC management. This appears appropriate in the circumstances of the evidence before me in this matter.
291. As of 22 April 2020, which was almost two months after his reception to the PCC, Michael had still not undergone a DOA review. He also had not been reviewed by a dentist or a general practitioner regarding his reports of pain. Attempts were made by SVCH staff to arrange for Michael to see a dentist on 27 March 2020, however, it appears, for reasons that are not known, that Michael was not brought by COs to the clinic for that review: see NCF at [169]-[170].
292. Michael’s descriptions in the referral forms about the pain and distress he was experiencing, the lengths to which he was resorting to sourcing illicit drugs, and his desperation makes for harrowing reading.
293. Counsel for SVCH submitted that the self-referral forms should be considered within the context of the volume of work required of SVCH nurses. I accept SVCH nurses work in difficult conditions. It was further submitted that SVCH received hundreds of self-referral forms from inmates every day and “*it is likely that many of these forms were similar in tone to some of those written by Michael.*” That may or may not be true – certainly, there is no other evidence

¹⁰² Transcript 21.3.2025, Johnston, T416.

¹⁰³ Second statement of Governor Taylor dated 21.2.2025: Vol 3A, Tab 202A, [68].

before me in relation to this issue. Whatever the case, it appears to me that Michael received an inadequate response to his self-referral forms. Ms Johnson was not surprised that Michael did not see a GP within his seven weeks in custody, despite his requests. As an outsider I find acceptance of this kind of time frame extremely troubling.

294. Given the evidence before me, I think it quite likely that Michael's request forms reflected the true extent of his cravings and what he was experiencing, particularly when one takes into account his reports to Community Corrections while on parole and the fact of him being assessed suitable for ORT in January 2020. While it is possible Michael may have embellished aspects of his reports in the hope this would result in a more rapid assessment and increase his prospects of being assessed eligible for ORT, there is really no evidence to suggest this was the case.
295. The apparent lack of action on the self-referral forms must have been frustrating and dispiriting to Michael. The Court was told that the self-referral form now includes a tear-off slip which is completed by a nurse and provided to the patient so that they are at least aware that their requests have been reviewed and actioned to the extent possible.¹⁰⁴ This may be an improvement, but what is required is action on waitlist timeframes.

Wait times for assessment for ORT in the community

296. Professor Lintzeris was asked questions about the general wait times in the community for assessment for ORT. He gave the following evidence:¹⁰⁵

"Q. Just to ask from a perspective of community treatment, if a patient presents to a GP and is indicating they consider that they are dependent on opiates or want to be assessed for an opiate replacement therapy in the community, what's the timeframe in your experience from presenting to a GP or to some sort of referral person to an actual assessment as to their eligibility?"

A. So it would vary considerably according to where you are in New South Wales. If you are in regional or rural New South Wales, one can expect long delays, as we see with longer delays for initiating any sort of - many health interventions in rural remote areas. If we were looking at more urbanised areas such as Wollongong, Newcastle, Sydney, then generally probably the biggest delay is actually getting the first appointment and finding a service provider. But if the patient knew a GP or presented to a public clinic, the public clinics generally have targets of priority patients should be given an appointment within three days, and for non-priority patients I believe an appointment should occur within two weeks. From that initial assessment, if the patient and doctor determine that treatment is indicated, then generally it is only a matter of days before the treatment is initiated under normal circumstances."

297. Professor Lintzeris agreed that, generally, the wait time in more urbanised areas of the community (Wollongong, Newcastle, or Sydney metropolitan area) between requesting assessment and commencing therapy would be in the order of two to three weeks, accepting that arrangements in the community do not always operate "*smoothly*".¹⁰⁶

¹⁰⁴ Transcript 21.3.2025, Johnston, T421.

¹⁰⁵ Transcript 21.3.2025, Professor Lintzeris, T430.

¹⁰⁶ Ibid T431.

Michael's reports of pain and the potential impacts of cravings on his behaviours

298. With respect to Michael's reports of experiencing pain, and the relationship that this may have had to his cravings, Professor Lintzeris opined:¹⁰⁷

"We cannot know with certainty as to Mr Black's motivations for his change in story over several weeks (from a denial of regular substance use or recent opioid and mental health treatment at initial presentation) – however it is recognised that some inmates will fabricate or exaggerate their medical history in order to be prescribed psychoactive medications (such as antidepressants, antipsychotics or opioid treatment). I also note that [Michael] was complaining of pain (leg pain and dental pain), which can increase an individual's cravings or desire for opioids, especially in individuals with a past history of opioid dependence...." (emphasis added)

299. Professor Lintzeris also gave evidence in the hearing that:¹⁰⁸

"So buprenorphine is an analgesic. It's an opioid analgesic medication. It's licensed and indicated for the treatment of pain, but the products that are actually licensed for pain in Australia are not high dose sublingual buprenorphine nor the long acting injectables. So it's actually low dose tablets and some patches that we have available to us in Australia specifically for the indication of pain management. However, many patients who are opioid dependent also have chronic pain.

So there is no barrier to using buprenorphine either sublingual high dose buprenorphine products such as Suboxone, or the injectable buprenorphine products such as buvidal or sublocade. They are often used in patients with comorbid opioid dependence and chronic pain. They tend to be quite effective for that role, and indeed standard care now would be for a patient with both chronic pain and opioid dependence, standard care would be that they would almost certainly end up on oral methadone or a high dose buprenorphine treatment program."

300. In Professor Lintzeris' view, Michael's post-mortem toxicology, which did not detect the presence of buprenorphine or methadone (which typically take three to five days to clear the system), pointed to Michael not having used buprenorphine in the period before his death.
301. As for the significance of the lack of any observation of injecting marks during autopsy, this did not exclude the possibility of injection as it is not uncommon for some persons to take steps to minimise the presence of obvious markings.¹⁰⁹ Moreover, Michael was found during autopsy to have had a syringe (with needle) hidden in the hem of his singlet top.¹¹⁰
302. Professor Lintzeris described the potential impact on a person's state of mind when that person is experiencing cravings and pain, stating:¹¹¹

"Q. If you were experiencing cravings or difficulties and you aren't able to source it, then that may impact on your state of mind?"

A. Correct. So if he had established a physical dependence, by that we mean regular use sufficient to cause tolerance and withdrawal when stopping his opioids, so if he had established that psychical dependence then one would expect that if he gone for three/four days or more without any opioids that his cravings would certainly increase. So his desire to use opioids would be greater if he hadn't used in preceding days, and then there's the issue of the reports of pain, and in particular the dental pain. And there is quite a lot of evidence that tells us that patients with opioid dependence have experienced pain. Pain is often a trigger for them to go and think about using opioids, whether or not that's a prescribe Endone tablet or an illicit dose of heroin or buprenorphine."

¹⁰⁷ Lintzeris Report dated 28.1.2025: Vol 8, Tab 255, p. 9.

¹⁰⁸ Transcript 21.3.2025, Professor Lintzeris, T431.

¹⁰⁹ Ibid T432-433.

¹¹⁰ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [50].

¹¹¹ Transcript 21.3.2025, Professor Lintzeris, T433.

303. I accept that if Michael was experiencing difficulties with cravings, along with related pain, in the days leading up to 22 April 2020, it is possible that may have contributed to him exhibiting irritability and agitation while he was in cell 4 that day. Further, it may have contributed to his actions when it became known that Mr Welford had brought diverted Suboxone into cell 4.
304. While I accept that this is a real possibility, a definitive finding in this respect cannot be made on the available evidence. Nevertheless, it underscores the importance of timely access to ORT assessment and therapy.

Overall

305. There were, collectively, missed opportunities for Michael to be medically assessed and to have received ORT treatment and treatment from a medical officer for his reports of pain before 22 April 2020.
306. There was a significant disparity in a person's access to assessment for ORT in the PCC as compared to that generally expected in the community.
307. This is of particular concern given the prevalence of illicit substances in custody and the potential for inmates to gravitate to illicit opioid use in custody owing to boredom and other stressors, even when they might not have had an opioid dependence before entering custody.
308. That is so even when making reasonable allowance for the undoubted demands the COVID-19 pandemic placed on SVCH at the PCC.
309. I am not critical of the particular staff involved and I accept that they were doing their best to meet the demands they faced with the resources at their disposal. This is clearly a systems and resourcing issue, but one that should be acknowledged and rectified.
310. Given the significant risks involved, the wait time for a review was unacceptable. It stemmed, in large part, from the limited resources available for the provision of this type of health care in custody.
311. The telling of Michael's story in this respect is of paramount importance. This is to ensure this issue is brought to the attention of the Executive, who bear responsibility for ensuring appropriate health care is available to persons who are deprived of their liberty by the State, and to the wider community. It is critically important that appropriate priority be given to the resourcing of this type of health care.
312. Counsel assisting submitted that there would be benefit in SVCH examining its systems to ensure wait times for inmates awaiting assessment for ORT in custody is captured. This picks up the recommendation of Professor Lintzeris in his supplementary report.¹¹²
313. Counsel for SVCH submitted that any systems review must be conducted by Justice Health because it would involve a review of the PAS system which is part of its responsibility. SVCH supports any functionality improvements to the PAS in order to enable greater collection of

¹¹² Lintzeris supplementary report 19.3.2025: Vol 8, Tab 255A, p. 2 [3].

data relating to the referral, waitlisting, assessment and provision of ORT to patients in custody.

314. Justice Health subsequently indicated that the relevant information can already be captured on the PAS system by filtering standardised entry formats rather than through using OST/OAT as a separate category. However, it is unclear to me whether SVCH is aware of this function.
315. Taking all the available information into account, I do not intend to make the recommendation. However, I urge SVCH to review this function and the operation of the PAS system and to seek further guidance from Justice Health if necessary.

Findings

316. For reasons stated above, I make the following formal findings pursuant to s 81 of the *Coroners Act 2009* (NSW) (***Coroners Act***):

Identity

The person who died was Michael Black.

Date of death

He died on 22 April 2020.

Place of death

He died at Parklea Correctional Centre, Parklea NSW.

Cause of death

The cause of death was a stab wound to the chest.

Manner of death

Michael was lawfully in custody. He was stabbed by a known person while confined in a crowded cell with numerous other inmates in the Reception Area. Deficiencies in the Parklea Correctional Centre's risk assessment/mitigation practices, search practices, and the management of inmates at the time (e.g. the number of inmates placed in the cell), and the fact that Michael had yet to be assessed for opioid substitution therapy by St Vincent's Correctional Health as he had requested, were contributing factors to what unfolded in the cell immediately before the infliction of the stab wound.

Recommendations

317. For reasons stated above, I make the following recommendations pursuant to s 82 of the *Coroners Act*:

To the Chief Executive of MTC

1. MTC review its procedures, instruction, and training as regards the conduct of Segregation Review Committee reviews and the formal lifting of segregation directions, having regard to the findings in these proceedings. This includes, but is not limited to, the importance of documenting reviews and the factors that were considered in determining

whether or not to lift a segregation direction (including the appropriate record keeping and/or file management for that documentation).

2. MTC review its procedures, instruction, and training as regard when an inmate should be considered for referral to the High Security Inmate Management Committee for consideration of designation pursuant to CSNSW Custodial Operations Policy and Procedure 3.5 (e.g., High Security or Extreme High Security) having regard to the findings in these proceedings.
3. MTC review its procedures with a view to expressly stipulating that specific correctional officers or supervisors who are working in the Reception Area in a given shift must expressly monitor the number of inmates placed in holding cells at a given time and to take steps to prevent unsafe numbers in these cells (including providing instruction on what action to take if an officer is concerned about cell numbers), having regard to the findings in these proceedings.
4. MTC urgently review its current limits on the maximum number of inmates that can be safely held in the cells within the PCC's Reception Area, having regard to the findings in these proceedings (this extends to potentially seeking advice from a work health and safety expert in this respect).
5. MTC review any training and instruction it provides IRT members in responding to a violent encounter within a cell having regard to any lessons that might be drawn from the events on 22 April 2020 and the findings in this matter (separate to that provided externally by the Corrective Services Security Operations Group).

To the Commissioner of CSNSW and the Chief Executive of MTC

6. CSNSW and MTC review its arrangements concerning the provision of Serious Incident Reports completed by CSNSW into the death of an inmate at an MTC-operated correctional centre to MTC, having regard to the findings made in these proceedings.

Conclusion

318. I offer my sincere thanks to the assisting team, counsel Christopher McGorey and Hannah Donaldson, and solicitors James Prindiville and Camilla Blome of the Crown Solicitor's Office.
319. I thank the former OIC, Detective Sergeant Lawler, for his assistance in preparing the brief of evidence, and the current OIC, Detective Sergeant Ball, for his assistance in these proceedings.
320. I thank Nicolle Lowe, Aboriginal Coronial Information and Support Program worker attached to this Court for her commitment, skills, and help.
321. I recognise the trauma of proceedings such as these on families and I once again offer my sincere condolences to Michael's family and thank them for their attendance.
322. I close this inquest.

Magistrate Harriet Grahame

Deputy State Coroner

Coroners Court of NSW, Lidcombe

22 August 2025

ANNEXURE: NON-CONTENTIOUS FACTS (NCF)

PARKLEA CORRECTIONAL CENTRE (PCC)

1. The PCC is classified as a maximum-security facility (a minimum-security compound, Area 4, is also situated within the PCC complex). It holds an inmate population of up to 1350 inmates. The Centre's population then and now is predominantly a remand population.¹
2. In 2020, the PCC was managed under a joint venture between private operators Management and Training Corporation Pty Ltd (**MTC**) and Broadspectrum Australia Pty Ltd (**MTC-Broadspectrum**) under an agreement made pursuant to s 238 (**the Deed**) of the *Crimes (Administration of Sentences) Act 1999 (CAS Act)*.² MTC-Broadspectrum was the employer of Correctional Officers (**COs**) who work at the PCC. MTC-Broadspectrum was responsible for instigating and managing disciplinary action in relation to their staff. Since 1 October 2022, the PCC has been operated and maintained by MTC alone.³
3. St Vincent's Hospital Sydney Ltd (Correctional Health) (**SVCH**) were (and currently are) contracted to provide healthcare services to inmates at the PCC.

CSNSW COPPS & MTC-BROADSPECTRUM PROCEDURES

4. Corrective Services NSW (**CSNSW**) has written operating procedures known as *Custodial Operations Policy and Procedures (COPPs)*.
5. The Deed required MTC-Broadspectrum to have written policies that reflected the outcomes identified in the services specification, including outcomes provided for by sections of the COPP. MTC-Broadspectrum policies were known as *Parklea Operating Policies (POPs)*. Additionally, the PCC Governor issued written instructions on specific matters such as "Searching".
6. CSNSW had COPPs relevant to the management of inmates considered to be a risk owing to violent behaviours and/or threat to the security of a correctional centre. The COPPs provide two pathways for the management of such inmates outside normal classification procedures (outlined below) through COPP 3.5 and COPP 3.6. The CAS Act and COPPs also provide for the making of segregated custody directions (or segregation orders) (outlined further below).

¹ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 3.

² Statement of Wayne Taylor: Vol 3B, Tab 202, p. 3.

³ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 3.

COPP 3.5

7. The first pathway arises under COPP 3.5, which provides a mechanism for the referral of an inmate to the High Security Inmate Management Committee (**HSIMC**), which is a sub-committee of the Serious Offenders Review Council (**SORC**).⁴
8. The SORC is constituted under the CAS Act (known as “Review Council”).⁵ It is constituted by “judicial members”, “official members”, and “community members”.⁶ It has a Management Committee known as the Serious Offenders Management Committee, which is empowered to establish sub-committees to exercise particular review functions.⁷ The HSIMC is one such sub-committee.
9. The Commissioner of CSNSW may, on the recommendation of the HSIMC, designate an inmate for management under COPP 3.5 as High Security (**HS**), Extreme High Security (**EHS**), National Security Interest (**NSI**), or Extreme High Risk Restricted (**EHRR**), which are designations referred to in cl 15 of the *Crimes (Administration of Sentences) Regulation 2014 (CAS Regulation)*.
10. Of most relevance to these inquest proceedings are the HS and EHS designations.
11. The HS threshold is defined as an inmate who constitutes (1) a danger to other people, or (2) a threat to good order and security. COPP 3.5 requires that HS inmates be housed at a medium or maximum security correctional centre. A designation of HS indicates that a period of monitoring is required for the inmate.⁸ Procedures and sanctions for EHS and EHRR do not ordinarily apply to HS inmates.
12. The EHS threshold is defined as an inmate who constitutes (1) an extreme danger to other people, or (2) an extreme threat to good order or security. COPP 3.5 requires EHS inmates to be housed at a maximum security correctional centre. Amongst other requirements, cells occupied by EHS inmates are to be searched regularly; EHS inmates are required to be moved into a different cell each month;⁹ and General Managers are to determine EHS access to other areas of a correctional centre based on local security assessments.
13. COPP 3.5 specifies that an inmate at risk of *extreme violence* is one whose “*offence history and behaviour demonstrates a substantiated capability to orchestrate extreme sets of violence which present an extraordinary risk to the correctional system, or in the event of an escape, the community at large*”. This concept of “extreme violence” informs the

⁴ COPP 3.5 as at 22 April 2020: Vol 4, Tab 203B, pp. 6-7.

⁵ Sections 195-199, CAS Act.

⁶ Section 195, CAS Act.

⁷ Section 206, CAS Act.

⁸ COPP 3.5 as at 22 April 2020: Vol 4, Tab 203B, [17.3].

⁹ COPP 3.5 as at 22 April 2020: Vol 4, Tab 203B, [17.5.1].

consideration of whether an inmate meets the lesser threshold for HS or the higher threshold for EHS.

14. Both sentenced and remand inmates holding a HS or EHS designation could be placed at the PCC as it is a maximum security facility. In contrast, an inmate designated EHRR would generally be placed at the High Risk Management Correctional Centre (**HRMCC**) at Goulburn.
15. A referral to the HSIMC may be made by senior officers at a particular correctional centre such as the Governor or the Manager of Security (**MOS**). An interim informal designation may be made pending the HSIMC reviewing and making an initial recommendation in the matter.
16. In its review, the HSIMC will have access to the inmate's custodial history and information about the event that was the catalyst for the referral, and it may also consider intelligence holdings. If an inmate is designated as a HS or EHS inmate on the HSIMC's recommendation, the HSIMC will carry out reviews from time to time and may make recommendations for the lifting or continuation of that designation.
17. It is open to the HSIMC to make recommendations or requests for assessments of an inmate (e.g., mental health assessment) to inform its review.

COPP 3.6

18. The second pathway arises under COPP 3.6, which provides a mechanism for the referral of an inmate to the Extreme Threat Inmate Management Committee (**ETIMC**).¹⁰
19. The ETIMC is part of CSNSW and is not part of the SORC. It also makes recommendations on the basis of information about the inmate including intelligence holdings. Its recommendation is made to the Governor of the correctional centre at which the inmate is placed, who may classify or treat an inmate as an Extreme Threat Inmate (**ETI**) under COPP 3.6 on the ETIMC's recommendation. The ETIMC may review that inmate thereafter and make further recommendations as to the closing or continuation of that classification.
20. COPP 3.6 provides that the ETI threshold will be established if an inmate demonstrates one or more specified indicators. One indicator is that of "violence", which can be manifested by involvement in extreme standover tactics (typically understood to concern organised gang standover as opposed to individual standover behaviour), and/or physical assaults on staff, inmates, or visitors; either individually or within a group.

¹⁰ COPP 3.6 as at 22 April 2020: Vol 4, Tab 203D.

21. Under COPP 3.6, the process generally involves:
- (1) Before an inmate is referred to the ETIMC for review, he or she will be issued a verbal warning. That warning may continue or be valid for a period of 12 months. It is intended to put the inmate on notice and provide him/her an opportunity to change their behaviours.
 - (2) If an inmate is considered not to have satisfactorily remedied his or her behaviour in response to a verbal warning, a written warning is then issued to the inmate. In practice, the inmate is managed as an ETI under COPP 3.6 upon the issuance of the written warning (or notice).
22. The ETIMC will review an inmate thereafter after 3 months and at subsequent intervals regarding the inmate's suitability to remain an ETI and to consider recommendations around other interventions (e.g., Behavioural Management Plan or Behavioural Management Contract under COPP 3.11). At the very least, the inmate will be reviewed by the ETIMC once per year.
23. It is possible for an inmate to be designated a HS or EHS inmate under COPP 3.5 and, simultaneously, for that inmate to be managed as an ETI under COPP 3.6. However, in practice, COPP 3.5 provides a greater suite of management options and restrictions as compared to COPP 3.6. The former option will typically be preferred over the latter in cases where an inmate has previously been managed, unsuccessfully, under COPP 3.6.

EMMETT SHEARD

Emmett Sheard's background as of August 2019

24. Emmett Sheard (DOB: 3 October 1991) first entered adult custody in mid-2010, then aged 18.
25. Between his entry into custody in mid-2010 and about August 2019 when he returned to custody, Mr Sheard spent about 8 ³/₄ years in custody, consisting of the following periods:¹¹
- (1) 30 to 31 July 2010;
 - (2) 7 September 2010 to 17 September 2013;
 - (3) 17 January 2014 to 28 July 2014;

¹¹ Sheard Inmate Profile: Vol 1, Tab 80, p. 10.

- (4) 18 August 2014 to 15 September 2014;
 - (5) 28 November 2014 to 6 January 2019;
 - (6) 6 March 2019 to 12 July 2019; and
 - (7) 20 August 2019 until 22 April 2020.
26. One of Mr Sheard's criminal convictions was for an aggravated break and enter and commit serious indictable offence committed in July 2010. That offending involved violence and the use of a weapon. Mr Sheard entered an occupied residential home of an elderly man while he was in possession of a knife/machete with two other co-accused. Mr Sheard had his face covered by a ski mask. During the invasion, the occupant suffered superficial lacerations to his hand and a fractured clavicle.¹² For this offence Mr Sheard received a sentence of 5 years imprisonment with a 2 year 6 month non-parole period (**NPP**).
27. Mr Sheard's criminal offences in the community were otherwise for drug and dishonesty offences rather than violence, however, Mr Sheard did come to the notice of Correctional authorities for violence and weapons in custody (outlined below).

Emmett Sheard's Extreme Threat Inmate Warning in 2016 and 2017

28. On 14 January 2016, while at Goulburn Correctional Centre, Mr Sheard was given an ETI verbal warning due to information that indicated he "*participated in activity and/or behaviour that presented as an extreme threat to the good order and security*" of a correctional centre.¹³
29. On 11 January 2017, a 12 month review of that warning indicated that Mr Sheard continued to engage in ETI activity, namely gaol unrest in May 2016 and the assault of an inmate in January 2017. As such, the verbal warning was extended for 12 months until 10 January 2018.
30. On 18 June 2017, Mr Sheard's ETI verbal warning was further continued with a review of incidents indicating that he had been involved in "group assault, disobey direction and possession of gaol made weapon". This warning was to remain active for 12 months (meaning an expiry on 17 June 2018).¹⁴

¹² Facts for H411359030 – Sheard: Vol 2, Tab 144.

¹³ CSNSW ETI Warning Review: Inquest Hearing Exhibit 10.

¹⁴ CSNSW ETI Warning Review: Inquest Hearing Exhibit 11, p. 1.

31. On 11 July 2018, Mr Sheard's ETI warning was reviewed with the outcome being that the warning was to be expired.¹⁵

Emmett Sheard is released to parole on 12 July 2019

32. On 12 July 2019, Mr Sheard was released to parole and commenced supervision with Community Corrections.

Emmett Sheard returns to custody on 20 August 2019

33. On about 20 August 2019, Mr Sheard was arrested for further alleged offending and remanded into custody. His parole was also revoked for non-compliance with supervision/new alleged offending.

Emmett Sheard enters MRRC on 26 August 2019

34. On 26 August 2019, Mr Sheard transferred to the Metropolitan Reception and Remand Centre (**MRRC**) which was operated by Corrective Services NSW (**CSNSW**).

35. On 27 August 2019, Mr Sheard underwent a reception screening intake assessment at MRRC. Under the prompt "Are there any alerts for this offender?", the answer was "Yes", with the following recorded in the comments: "ASOC STG **ETIMC** ALRGY ASTHMA"¹⁶ (emphasis added). As clarified in oral evidence by CSNSW General Manager of Statewide Operations, Malcolm Brown, the ETIMC alert was no longer active at this time. Instead, the active alert related to Mr Sheard's non-association with specific security threat groups.¹⁷

36. On 30 August 2019, Mr Sheard was assessed as being at risk and was subsequently placed in protective custody to a Protection Non-Association (**PRNA**) designation. Mr Sheard's risk was focussed on his vulnerability as an inmate, rather than a risk being posed by Mr Sheard to other inmates. Mr Sheard was assessed as being the second highest level of vulnerability protection.¹⁸

¹⁵ CSNSW ETI Warning Review: Inquest Hearing Exhibit 11, p. 2.

¹⁶ Statement of Susan Mitchell: Vol 3A, Tab 188EA, p. 3.

¹⁷ See Inquest Transcript: Day 3, T233.5-30. .

¹⁸ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 10.

Emmett Sheard transfers to the PCC on 2 September 2019

37. On 2 September 2019, Mr Sheard was transferred from MRRC to PCC. He had been deemed unsuitable for placement at the MRRC due to concerns for Mr Sheard's safety by reason of certain groups/persons located at the MRRC.¹⁹
38. Mr Sheard's designation, determined while he was at the MRRC, was still active on his transfer to PCC, however, on arrival to the PCC he was no longer deemed to be in need of protection and was subsequently housed in the main population.
39. Mr Sheard's custodial classification was A2U, which deemed him suitable for housing at PCC, which was a maximum security facility.
40. At the time of his transfer, Mr Sheard had "active" alerts within the OIMS described as "*CIG (Alert Type) – ETIMC Assessment (Alert Code) – Refer to the STG Module prior to movement or placement (Comments)*". Even though the alert showed as "active" on the OIMS alerts and STG modules, when opened, the affiliations tab showed that the ETIMC alert had expired on 11 July 2018. The [ETIMC] alert showed as "active" because two other active alerts remained, which is why the first screen showed "active".²⁰

Transfer of inmates from another correctional centre to the PCC

41. The following policies inform the transfer of inmates between correctional centres in NSW:
 - (1) Offender Management and Programs, CSNSW – Inmate Classification and Placement, 'Section 23 Transfer of Inmates' (version 2.0) dated 2 February 2021 (current version); and
 - (2) Offender Management and Programs, CSNSW – Inmate Classification and Placement, 'Movement Holds' (version 2.0) dated 2 February 2021 (current version).
42. Inmates who are transferred to the PCC from another correctional centre are assessed at the transferring centre before their reception at the PCC.²¹ Upon reception of inmates transferring from other centres, officers at the PCC do not change existing classifications or security determinations in relation to inmates. If and when a remand inmate is sentenced

¹⁹ In a statement prepared for this inquest, Acting Governor Lee Caines (CSNSW) stated that Mr Sheard, at the time of his transfer from MRRC on 2 September 2019, was not referred for consideration for EHRR Security or EHS designation as the information available to MRRC did not provide sufficient grounds to justify such a referral: Statement of Lee Caines: Vol 3A, Tab 188C, p. 4.

²⁰ Evidence of Malcolm Brown, Inquest Transcript, Day 3, T233.10.

²¹ Statement of Wayne Taylor: Vol 3B, Tab 202.

during his housing at the PCC, the inmate will then undergo a new classification assessment.

43. If the transferring inmate has present or historic extreme high risk and/or security designation, officers at the PCC request that CSNSW maintain or reactivate the designation until further assessment can be undertaken. Officers at the PCC (the functional manager or authorised representative) were not required to review historical case notes or case files for the purpose of determining the housing of inmates unless the transferring centre or transfer staff advised the PCC of violent acts committed by the inmate immediately prior to reception at the PCC, however, they were required to consult the information sources listed on the reception transfer checklist.²² Mr Sheard did not have EHS or security designation at the time of his transfer from MRRC to PCC.
44. There was no policy at the PCC mandating a fresh formal risk assessment process before cell allocation.
45. Mr Sheard's active alert for "ETIMC Assessment" would have been visible to the PCC officer responsible for reviewing his initial placement upon his arrival to the PCC. That officer would have been able to access the alert through OIMS, which would have revealed (i) Mr Sheard had been subject to an ETI warning between 2016 and 2018 (now closed off and no longer active) and (ii) he had two active non-association alerts. That officer would not have been able to access specific ETI records for Mr Sheard for the period 2016-2018 through OIMS. Access to that was restricted to particular officers (e.g., those in intelligence).
46. The designations and alerts that were in place at the time of Mr Sheard's transfer to the PCC did not themselves trigger or mandate the PCC (MTC-Broadspectrum) officers to conduct a risk assessment or to consider whether Mr Sheard warranted referral to the HSIMC or ETIMC. The COPP does not require reassessment upon transfer between corrective centres. The PCC officers, in all likelihood, would have expected that if there was any basis for such a referral at that point to the HSIMC or ETIMC, that would have been identified at the MRRC and that process commenced there (at least before transfer).

Emmett Sheard's custodial history as of 2 September 2019

47. During his time in custody before 2 September 2019, Mr Sheard was charged with alleged institutional misconduct offences and criminal offences committed in custody. As of 2 September 2019, relevant to those concerning violence in custody or goal made weapons were the following incidents:

²² Statement of M Brown dated 19 February 2025: Vol 3A, Tab 185A, [5].

Date	Incident
28 Jun 2019	Fight
13 Jun 2019	Fight with another inmate in a reception holding yard waiting for court, and possession of weapon
3 Oct 2018	Fight with several other inmates. Mr Sheard was identified as one of the main assailants
19 Jul 2018	Fight
29 Apr 2018	Fight
30 Jan 2018	Possess offensive weapon
8 April 2017	Physical altercation with another inmate
3 Jan 2017	Criminally charged (convicted): Assault occasioning actual bodily harm in company, committed on another inmate (outlined below)
25 Oct 2016	Assaults
26 Jul 2016	Assaults
5 May 2016	Assault – hiding behind door with a broom handle, assaults another inmate
12 Dec 2015	Assaults
1 Jun 2014	Fight
16 Jan 2013	Removed a metal ruler with the intention of making a weapon
3 Sep 2011	Fight

AOABH offence committed on 3 January 2017

48. On 3 January 2017, while an inmate at the Goulburn Correctional Centre, Mr Sheard and two other co-accused attacked another inmate (appeared pre-planned). While the victim was being held in a chokehold on the ground, Mr Sheard threw a number of punches at the victim's body.
49. After other inmates intervened, Mr Sheard ran back towards the victim and threw about 12 punches at the victim's head, with the final six making contact with the right side of the victim's face.

50. The victim's head repeatedly bounced off the concrete. The last four punches were made after the victim appeared to lose consciousness. The punches stopped when another inmate intervened.
51. While the victim was then lying unconscious in the yard, Mr Sheard kicked him to the side of the head.²³
52. For this offence Mr Sheard was sentenced to 22 months' imprisonment with a 16-month NPP.

Misconduct / criminal offences by Emmett Sheard in September and October 2019

53. In the period September to October 2019, Mr Sheard was charged with (a) possession of a weapon (concealed in front of shorts) on 26 September 2019²⁴ and (b) fight and possession of a weapon on 15 October 2019.

Emmett Sheard placed on Behavioural Management Plan from 21 October to 9 December 2019

54. Mr Sheard was placed on a behavioural management plan (**BMP**) on 21 October 2019 until 9 December 2019 (7 weeks).²⁵
55. BMPs are devised and entered into with an inmate following patterns of behaviour that poses risk to the centre but where the unacceptable behaviours fall short of being a correctional offence.
56. Mr Sheard's BMP recorded:
1. *"Violence, involvement in violent behaviour within centre and wing.*
 2. *Must not receive any negative reports from any location*
 3. *Must not receive any further misconduct reports or CC charges*
 4. *Report to supervisor weekly basis*
 5. *Must refrain from any abusive and/or aggressive behaviours towards other inmates and/or staff*
 6. *Must comply with Centre and unit regulations and rules at all times"*

²³ Facts for H63777621 – Sheard: Vol 2, Tab 145.

²⁴ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 103 (Document 9).

²⁵ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 70 (Document 7).

Emmett Sheard commits reckless wounding on an inmate and is placed in segregation on 24 December 2019

57. On 24 December 2019, Mr Sheard was being escorted by a CO through the PCC from Area 1 to Area 5. Without warning, Mr Sheard approached another inmate (sweeper) and pulled a “shiv” from the front of his pants. Mr Sheard held the shiv in his right hand behind his back. Mr Sheard hugged the victim at which point he stabbed the victim to his right bicep and right side of his ribs. The victim reported not knowing who Mr Sheard was.
58. Mr Sheard was criminally charged with this offence in late February 2020 (initially charged with recklessly cause grievous bodily harm). These proceedings were not yet finalised at the time of Michael’s death.
59. Mr Sheard later pleaded guilty and was sentenced to imprisonment for this offence (after Michael’s death).
60. In a psychiatric report prepared for those sentencing proceedings, Mr Sheard reported that he had assaulted a random individual to avoid being placed back in Area 5 because he was concerned for his safety in Area 5.

Making of a segregation direction for Emmett Sheard on 24 December 2019

61. Mr Sheard had been subject to two segregation directions/orders before 24 December 2019 for alleged assaults and/or possible use of weapons (Mr Sheard was subject to other segregation directions for non-violence/weapon reasons),²⁶ being:
 - (1) 3 October 2018 to 23 October 2018; and
 - (2) 18 June 2017 to 19 September 2017.
62. On 24 December 2019, following the stabbing of another inmate, an initial 14 day segregation direction for Mr Sheard (expiring 6 January) was recommended by Correctional Manager Anthony Mott and was approved by PCC Governor Paul Baker on 2 January 2020.

Policies/protocols concerning the segregation of inmates

63. The CAS Act provides legislative authority regarding segregation of inmates at correctional centres in NSW.²⁷

²⁶ Sheard segregation records: Vol 9, Tab 257, pp. 71-115.
²⁷ Relevantly, sections 10, 12, and 16.

64. CSNSW COPP 3.4 provided relevant CSNSW guidelines for segregation custody directions or orders (**segregation orders**).
65. Segregation at the PCC was to be managed in the same way as in all other correctional centres in NSW. MTC-Broadspectrum were subject to the requirements set out in the COPPs, specifically section 3 – Segregation.
66. At the PCC, the MTC-Broadspectrum Policy *POP 4.16 – Protective Custody and Segregation (v 2)* was applicable at this time.
67. Inmate segregation orders are imposed at the discretion of PCC staff and require approval by the Governor.
68. In accordance with the Output Specification, MTC-Broadspectrum was required to manage inmates who have been identified as a security risk to the PCC by:
 - (1) Ensuring that inmate movement through the Correctional Complex is planned and organised, reflects the level of risk posed by the inmate, and responds to changing events; or
 - (2) Develop a Case Plan based on the results of assessments conducted on the inmate such as the risk of re-offending. This is only required under certain circumstances/timeframes as outlined in s. 1.2.2 of the Output Specification.
69. Section 3.4 of the COPP required MTC-Broadspectrum's Case Management Unit and the Segregation Review Committee (**SRC**) to conduct weekly reviews incorporating an assessment of the risk to the inmate and the risk they may pose to staff and other inmates if returned to normal discipline.
70. In early 2020, the PCC's weekly SRC reviews were led by either the Governor or the MOS (Megan Lawlor). Area Managers responsible for the accommodation areas, in which inmates the subject of segregation orders were typically placed, would also attend if available and would be able to give input into the SRC's decision (i.e., whether to recommend the continuation of segregation or the lifting of the order).
71. The SRC's weekly review involved the SRC doing a walkthrough, which involved sighting and speaking briefly to each segregated inmate in his segregation cell. The Segregation Area Manager or Segregation Supervisor may also accompany the SRC in their walkthrough. The Segregation Supervisor would advise the SRC whether any behaviour difficulty or non-ompliance had arisen for a particular inmate since the last review, however, he or she did not take part in the SRC's determination.

72. Typically, a SVCH mental health nurse would accompany the SRC members in their walkthrough. However, this was for the purposes of being on hand to engage with an inmate if he requested treatment and not for the purposes of having input into the SRC's determinations.
73. On occasion, a psychologist employed by MTC-Broadspectrum would also accompany the SRC on its walkthrough. However, this was primarily for the purpose of being on hand if the inmate required psychological intervention and not for the purposes of providing input into the SRC's determinations.
74. Segregation orders that last longer than 14 days were to be sent by the PCC Governor's Executive Assistant²⁸ to the CSNSW General Manager of Custodial Corrections, Statewide Operations, for approval.
75. MTC-Broadspectrum were required to ensure that:²⁹
- (1) Inmate segregated custody directions were completed, authorised, and reviewed in accordance with legislation and policy; and
 - (2) An individual Inmate Management Plan be developed by the correctional centre and addresses the inmate behaviour which resulted in the segregation and provides a plan for the transfer of the inmate to the mainstream population.

Extension/review of Emmett Sheard's segregation direction in January 2020

76. On 2 January 2020, CO Aimee Flynn (Area Manager) recommended a three month segregation order extension which was approved by PCC Governor Paul Baker on 6 January 2020 (this extension was confirmed by Terry Murrell, Director of Custodial Operations on 14 January 2020).
77. On 11 January 2020, Mr Sheard was advised of his right to apply to have the Serious Offenders Review Council (**SORC**) review the segregated custody direction. Mr Sheard was provided with a copy of the Inmate Acknowledgment form.³⁰ There is no record on Mr Sheard's case management file or his OIMS profile indicating that he applied to have the decision reviewed.

²⁸ In 2020, Colleen Hopwood was the Governor's Executive Assistant. Ms Hopwood passed away in 2023.

²⁹ Section 2.7.2.2 of Schedule 3 – Output Specifications of the Parklea Correctional Complex Management Deed entered into between the NSW Government and MTC.

³⁰ Sheard segregation records: Vol 9, Tab 257, p. 124.

Review of Mr Sheard's segregation direction on 16 and 23 January 2020

78. The SRC meetings were held on 16 and 23 January 2020 during which Mr Sheard's segregation direction was reviewed.

Lifting/revocation of the segregation direction for Emmett Sheard on 31 January 2020

79. Part 10 of COPP 3.4 permitted the Governor (or delegate) to revoke a segregation direction if it could be determined that:

- (1) The original threat(s) no longer exists; and/or
- (2) An appropriate means of eliminating the threat is available.

80. Procedure for revocation of a segregation order is outlined at Part 10.3 of COPP 3.4, including a requirement that a segregated custody revocation direction be completed, clearly outlining the reason/s why the direction is being revoked.

81. The usual practice was for the Governor to revoke a segregation order on the recommendation of the SRC.

82. On either 30 or 31 January 2020, Mr Sheard's segregation order was reviewed during the weekly SRC meeting. It appears the SRC recommended that Mr Sheard be permitted to return to general housing (this considers the fact of the revocation by the Governor).

83. On 30 January 2020:

- (1) There was no Segregation Area Manager (in the absence of an Area Manager, officers reported to the Shift Manager on duty).
- (2) Warwick Aston was the Segregation Correctional Supervisor.
- (3) Anthony Mott was the Area Manager for Area 1 (being the Area in which the offence was committed).
- (4) Andrew Redden was the Support Services Psychologist.

84. Mr Sheard's OIMS case note dated 30 January 2020 reads: "*Compliant with wing routine. Nil issues. Seen by Seg Review Committee today. Seg to be revoked shortly*".³¹

85. According to Area Manager Anthony Mott, a SRC meeting planned for 30 January 2020 may have been postponed to 31 January 2020 due to the unavailability of Area Managers

³¹ Sheard OIMS case notes – April 2017 to April 2020: Inquest Hearing Exhibit 4, p. 80.

to attend on 30 January. The SRC minutes for 31 January 2020 do not record any discussion in relation to Mr Sheard.³²

86. On 31 January 2020, Governor Paul Baker approved the revocation of Mr Sheard's segregation direction.
87. The Review of Segregated Custody Direction form placed on Mr Sheard's file is unsigned. It indicated that the segregation was no longer necessary to secure the good order and discipline within a correctional centre. No comments or reasons were added to the form.³³ Further records of the reasons for any recommendation by the SRC to revoke that direction, and/or Governor Baker's reasons for doing so, have not been located in Mr Sheard's records.

Emmett Sheard charged with misconduct offences concerning possession of weapons or violence in February and March 2020

88. In the period February and March 2020, Mr Sheard was charged with the following misconduct offences:³⁴

Date	Incident
23 Feb 2020	Possession of a gaol made weapon hidden in front of underwear ³⁵
10 Mar 2020	Suspected as being involved in assault (watch of victim found in Mr Sheard's cell on 13 March 2020) ³⁶
25 Mar 2020 (12:21pm)	Weapon found in inmate property tub ³⁷
25 Mar 2020 (2:02pm)	Possession of gaol made weapon (modified paintbrush hidden in waistband of pants) ³⁸

89. Segregation directions were not made with respect to the above events. Mr Sheard remained in the mainstream population in this period.

³² Statement of Anthony Mott: Vol 3B, Tab 201B.

³³ Statement of Anthony Mott: Vol 3B, Tab 201B, p. 14.

³⁴ Sheard Inmate Profile: Vol 1, Tab 80.

³⁵ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 99 (Document 9).

³⁶ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 97 (Document 9).

³⁷ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 95 (Document 9).

³⁸ Statement of Wayne Taylor: Vol 3B, Tab 202, p. 93 (Document 9).

MICHAEL BLACK

Prior offences and periods in custody between 2005 and 2019

90. Michael (DOB 8 April 1987) first entered adult custody in July 2005. He served several periods in custody, either on remand and/or as a sentenced prisoner, between 2005 and 2019.
91. Some of Michael's past criminal convictions (before February 2020) appeared related to substance misuse on his part.
92. A psychological report completed on 6 November 2018, for use in his sentencing proceedings, noted Michael's reported history of difficulties with cannabis, alcohol, and methamphetamines use since his teens. In the view of the assessing psychologist: (i) Michael met the criteria at that time for a *Stimulant Use Disorder, Moderate, Amphetamine-type substance* (in sustained remission in a controlled environment); and (ii) a referral for assessment for Compulsory Drug Treatment (high intensity) within a correctional environment was recommended.³⁹
93. Michael had a history of substance related misconduct offences in custody. Between March 2006 and June 2019, he incurred nine separate *fail prescribed drug test* offences and two *possess drug implement* offences.⁴⁰
94. As of 28 February 2020, relevant to those concerning violence or goal made weapons were the following incidents:

Date	Incident
19 Apr 2019	Fight
5 Nov 2018	Fight
16 Oct 2018	Fight
28 Jul 2018	Gaol made improvised weapon in cell
24 Nov 2017	Fight
31 Oct 2017	Assault on another inmate – kicks to head and face
20 Feb 2016	Assault on a Correctional Officer: Michael was reportedly observed carrying drug items on him, when questioned and directed to hand

³⁹ North report (2018): Vol 2, Tab 150.

⁴⁰ Black Inmate profile: Vol 1, Tab 79, pp. 5-6.

Date	Incident
	them over he assaulted the officer (made contact pushing past the officer)
24 Nov 2016	Fight
7 Oct 2013	Fight
17 Aug 2012	Fight
1 Apr 2011	Assault on another inmate
14 Feb 2011	Fight
30 Dec 2011	Abusive towards staff and spat at them
8 Jun 2010	Fight
23 Feb 2009	Fight
3 Nov 2008	Assault on another inmate
11 Jan 2007	Fight

95. Michael was subject to several segregation directions between 2008 and 2019, including for reported assaults or threats of violence.⁴¹

Michael's release to parole on 12 November 2019

96. On 12 November 2019, Michael was released to parole. This was in respect to the following sentences:

- (1) A sentence imposed on 12 November 2018: a total of 4 years 3 months imprisonment commencing 17 October 2016 (concluding 16 January 2021) with a 2 year 9 month NPP (expiring 16 July 2019).⁴²
- (2) A sentence imposed on 5 July 2019: a total of 2 years 7 months imprisonment (concluding 4 February 2022) with a 4 month NPP (expiring 4 November 2019).⁴³

Michael is charged with new alleged criminal offences in January/February 2020

97. Michael was charged with new alleged offences during his parole period. These were allegedly committed in January and February 2020. It included possession of a prohibited

⁴¹ Michael was subject to a total of 14 segregation orders before 2020 (Black Inmate Profile: Vol 1, Tab 79, pp. 4-5).

⁴² Sentence concerned charges for aggravated break and enter offences laid in 2016.

⁴³ Sentence concerned charges of possessing an unregistered firearm, not keeping a firearm safely and possession of unauthorised prohibited firearm (laid in 2018).

drug, use of a prohibited weapon, take and drive a vehicle without consent, and robbery whilst armed with a dangerous weapon.⁴⁴ These charges had not been finalised at the time of his death.

Michael's substance use in the community between November 2019 and February 2020 and his engagement in buprenorphine treatment

98. On 20 November 2019, Community Corrections (supervising Michael) recorded that Michael returned a positive drug test for opiates. Michael was then provided an intervention plan which included referral to a general practitioner for assessment for the Buprenorphine Program (**BUP**) and provided details of the Illawarra Drug and Alcohol Service (**IDAS**) for assessment.⁴⁵
99. On 28 November 2019, during reporting, Michael admitted to not having arranged for “dosing” at the methadone clinic and to ongoing buprenorphine and “ice” use in the community. He was provided contact details for the Denison St Methadone Clinic in Wollongong.⁴⁶
100. On 9 December 2019, during reporting, Michael confirmed that he had an appointment that day with the Denison St Methadone Clinic and admitted to ongoing buprenorphine use in the community.
101. On 12 December 2019, Michael was noted to have an appointment to be reviewed by a “dosing” nurse at the Bungora Methadone Clinic in Wollongong (part of the IDAS) on 23 December 2019.
102. On 31 December 2019, Michael reported not having made progress with the “dosing” service assessment.
103. On 14 January 2020, Michael reported not having yet obtained a General Practitioner referral for the BUP or attending the Denison St Clinic for assessment. He reported he was reducing his use of buprenorphine to only every few days.
104. On 22 January 2020, Community Corrections received a call from Michael's general practitioner, Dr Leong, asking about the referrals Michael required. Dr Leong reported that Michael said he required referral to the BUP as he had been illegally obtaining the substance in community for several weeks now. Michael was provided details of Bungora Methadone Clinic and Denison St Clinic for referral.

⁴⁴ Black criminal history: Vol 2, Tab 149, pp. 62-63.

⁴⁵ Black case notes: Vol 3A, Tab 183, commencing at p. 268.

⁴⁶ This clinic in Wollongong was closed in 2024.

105. On 23 January 2020, Michael was approved for buprenorphine while he was in the community.⁴⁷ The NSW Pharmaceutical Regulatory Unit (**PRU**) approval listed the Denison St Clinic in Wollongong as the approved dosing Centre. The authority had a condition that it was to be rendered invalid if the Centre was no longer prescribing buprenorphine for Michael. The Centre was to notify the PRU by completing an exit form for Michael as soon as practicable after this occurred.
106. On 24 January 2020, during reporting, Michael reported having attended the Denison St Clinic and completed paperwork. He was due to return at 11:30am that day to complete admission. He expected to commence on the “MERIT” program on 28 January 2020.
107. On 28 January 2020, during reporting, Michael reported not having yet attended the Denison St Clinic for “dosing”. He also reported continuing/ongoing use of buprenorphine.
108. On 5 February 2020, an application form for “*Exit from Methadone or Buprenorphine Treatment under the NSW Opioid Treatment Program*” was completed and Michael was exited from the program as he did not commence treatment at the Denison St Clinic.
109. On 11 February 2020, during reporting, Michael reported using buprenorphine daily and having failed to attend the Dennison St Clinic for dosing. He reported using around half a “*strip*” of buprenorphine per day.
110. By way of additional information, on 21 April 2020, a Services and Programs Officer (**SAPO**) from MTC completed an LSI-R assessment for Michael. This was an assessment of his criminogenic needs and risks. It is typically completed to inform supervision by Community Corrections. The LSI-R assessment included information from Michael (by way of his self-report) about his alcohol and drug use, including that started using ice and cannabis at age 14 and that he currently used ‘heroin’, ‘ice’, and ‘bupe’ at least two times per week and that he had used ‘ice’ and ‘bupe’ while on parole. The information included a note that Michael reported to the SAPO that his “Partner expresses concern.” The SAPO also noted that Michael had attempted to gain access to the methadone program via his GP.⁴⁸

Revocation of Michael’s parole on 26 February 2020

111. On 26 February 2020, the State Parole Authority revoked Michael’s parole for a sentence which had been imposed on 5 July 2019 for firearm offences. The sentence imposed on 5

⁴⁷ NSW Health – Black SafeScript and PRU: Vol 7, Tab 249A.
⁴⁸ Black Case Notes: Vol 3A, Tab 183, p. 289.

July 2019 was 2 years and 7 months imprisonment, with a 4-month non-parole period, beginning 5 July 2019 to end 4 February 2022.⁴⁹

Michael's report on 26 February 2020 following his arrest

112. On 26 February 2020, Michael was interviewed for the purpose of completing a New Inmate Lodgement and Special Instruction Sheet.⁵⁰
113. In that lodgement sheet, the following was recorded for Michael:⁵¹
- (1) No immediate medical issues.
 - (2) Not receiving any mental health treatment.
 - (3) Not taking any prescribed medication.
 - (4) Not an alcoholic, recreational drug user, or user of non-prescribed medication.
 - (5) Not on the methadone program.
 - (6) No special needs.
114. The information recorded on the lodgement sheet, based on Michael's self-report, that Michael was not using non-prescribed medication is inconsistent with the information outlined above concerning his use of non-prescribed buprenorphine in the community between November 2019 and February 2020.
115. Assuming Michael reported that information, the reasons or motivation for him doing so is not known.

Michael enters custody and his transfer from ALCC to the PCC on 26 to 28 February 2020

116. On 26 February 2020, Michael entered custody at the Amber Laurel Correctional Centre.⁵²
117. On 28 February 2020, Michael was transferred to the PCC where he remained until his death.⁵³

⁴⁹ Black Inmate Profile: Vol 1, Tab 79; Black Criminal History: Vol 1, Tab 149, pp. pp. 60-61.

⁵⁰ Black Justice Health Records: Vol 7, Tab 248, p. 551.

⁵¹ Black Justice Health Records: Vol 7, Tab 248, p. 555.

⁵² Black Inmate Profile: Vol 1, Tab 79.

⁵³ Black Case Notes: Vol 3A, Tab 183, p. 281.

Reception Assessment Screening (RSA) for Michael at the PCC on 28 February 2020

118. Upon his reception to the PCC, Michael underwent reception screening with Registered Nurse Bastola, who was employed with SVCH.
119. RN Bastola completed an electronic reception screening assessment (**RSA**) form.
120. The RSA is electronically stored within the Justice Health Electronic Health System (**JHeHS**).
121. The completed RSA relevantly recorded:
 - (1) Michael was not currently taking any medications;
 - (2) Michael had recently been in hospital and was treated for a broken leg;
 - (3) Michael had not used drugs in the 4 weeks prior to his incarceration;
 - (4) Michael had not used benzodiazepines in the 4 weeks prior to his incarceration;
 - (5) Michael had not used heroin in the 4 weeks prior to his incarceration;
 - (6) Michael had not used other prescribed opioids in the 4 weeks prior to his incarceration;
 - (7) Michael had not used other non-prescribed opioids in the 4 weeks prior to his incarceration;
 - (8) Michael had not used non-prescribed pharmaceutical medications in the 4 weeks prior to his incarceration;
 - (9) Michael had not used stimulant type substances in the 4 weeks prior to his incarceration;
 - (10) Michael had not used cannabis in the 4 weeks prior to his incarceration;
 - (11) Michael had not used new psychoactive substances in the 4 weeks prior to his incarceration;
 - (12) Michael had used other drugs in the 4 weeks prior to his incarcerations, namely, half a strip of non-prescribed Suboxone weekly (in the community before entry into custody) and he last used this one week prior;
 - (13) Michael was neither intoxicated nor withdrawing from drugs;

- (14) Michael was not currently on opioid substitution treatment; and
- (15) Michael was not on other medications for substance use issues.⁵⁴

Referrals made upon completion of the RSA on 28 February 2020

- 122. RN Bastola entered Michael on waitlists, through the electronic Patient Administration System (**PAS**), for reviews by:⁵⁵
 - (1) The Drug and Alcohol Nurse (Priority 2 - Semi Urgent);
 - (2) The Mental Health Nurse (Priority 3 – Non Urgent); and
 - (3) The Primary Health Nurse (Priority 4 – routine).
- 123. When entering Michael on the waitlist for a mental health nurse review, RN Bastola made an entry in PAS for the Mental Health nurse: “*Stated feeling down. History of TOSH. Hearing command voices. Please R/v patient current mental status. States was on medication. ROI completed*”.⁵⁶ The RSA also noted a diagnosis of depression since 2016.⁵⁷
- 124. The nurse completing the RSA may place a patient (inmate) onto a waiting list/s if further assessment is indicated. The nurse would include a triage category as part of a waitlist entry. The specific team responsible for each waitlist would then review entries and re-triage patients where indicated and book appointments, however, the team may need to cancel and re-book patients depending on patient need/acuity and other patient priorities.⁵⁸
- 125. As at March 2020, the following average wait times existed:⁵⁹
 - (1) Dentist review for management of dental pain: 54.8 days.
 - (2) Review of medication for treatment of mental health: 21.82 days for a Mental Health Nurse Practitioner and 64.36 days for a Psychiatrist.
 - (3) GP review regarding general pain (for example as Michael expressed in his leg and dental pain): 69.59 days.

7. (Data concerning SVCH waitlists assessment for opioid agonist therapy/opioid substitution

⁵⁴ SVCH Records Black: Vol 7, Tab 249, p. 37.

⁵⁵ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A, p. 5 [27]-[31].

⁵⁶ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A, p. 6 [32].

⁵⁷ During a clinical assessment on 15 November 2018, while Michael was in custody at MRRC, he was recorded as being prescribed mirtazapine, 30mg dose. He is recorded as having commenced on that medication on 18 May 2018 (Black Justice Health Records: Vol 7, Tab 248, p. 587).

⁵⁸ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A.

⁵⁹ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A.

therapy for March/April 2020 is not available).

Health Problem Notification Form (HPNF) completed on 28 February 2020

126. On 28 February 2020, RN Bastola also updated a Health Problem Notification Form (**HPNF**) which was provided to an MTC-Broadspectrum officer.⁶⁰ The HPNF noted Michael had *“Previous custody experience, denied any self harm or suicidal ideation at present. Guarantee own safety. Denied any acute medical health or MH issues”*. It recommended *“Normal cell placement”*.

Collateral information obtained post completion of the RSA

127. During the RSA process, Michael signed the appropriate form to provide consent to SVCH to obtain health information from external agencies. SVCH then made an urgent “request for information” to Illawarra Medical Services, based on the information provided by Michael during the RSA.⁶¹
128. The information requested of Illawarra Medical Services was *“all the medication and surgical history”*.
129. The medical information provided by Illawarra Medical Services related to the care and treatment of Michael at Wollongong Hospital in relation to his broken right leg (as reported by Michael during the RSA) and set out that upon discharge on 17 December 2019, Michael was prescribed antibiotic Diclocil 500mg, one capsule four times per day.⁶² The medical information provided by Illawarra Medical Services did not include any reference to his assessment for buprenorphine therapy.
130. The SVCH records do not include any information from any source, including from CSNSW or Community Corrections, about the non-prescribed use of Suboxone reported by Michael (except for the reference in the RSA) or his assessment in the community for access to the NSW Opioid Treatment Program.

Opioid substitution program and healthcare in custody

131. Opioid substitution therapy (**OST**) (also known as opioid agonist therapy (**OAT**) or opioid replacement therapy (**ORT**)) is intended to assist an inmate with the management of cravings and/or withdrawal.

⁶⁰ Fourth Statement of Kirsty Johnston: Vol 8, Tab 253A, p. 6 [33] (HPNF is annex “KJ-3” at p. 14).

⁶¹ SVCH Records Black: Vol 7, Tab 249, p. 41.

⁶² Black Justice Health Records: Vol 7, Tab 248, p. 578.

132. OAT is indicated as a treatment for individuals with a diagnosed opioid dependence. Its use is governed by Therapeutic Goods Administration requirements and the *NSW Clinical Guidelines: Treatment of Opioid Dependence 2018*.⁶³
133. The standard for opioid dependence derives from the ICD-11 criteria⁶⁴ for opioid dependence or DSM-5 criteria⁶⁵ for Moderate to Severe Opioid Use Disorder.
134. An assessment for dependence typically considers a patient's reported history of use, physical examination, laboratory investigations (including urine screens) and available collateral information such as reports from health care providers, family and prescription monitoring systems.⁶⁶
135. In 2020, and now, the Justice Health and Forensic Health Network (**Justice Health**) and SVCH provided OST/OAT to inmates in custody.
136. In early 2020, this was provided for under Justice's Health's written policy, *OST No.1 – Assess & Commencement for Opioid Substitution Treatment* (Jan 2019) (**OST No.1**).
137. As at early 2020, Justice Health was yet to roll out the shift to the use of long-acting injectable buprenorphine (Buvidal). Justice Health's policy provided for the prescription of Suboxone wafers or methadone (liquid) to patients assessed suitable for OST. All three medications are a Schedule 8 drug and require approval of the NSW Pharmaceutical Regulatory Unit (**PRU**) to prescribe.
138. As of 2019 and early 2020, there was a cap on the number of inmates who could receive OST through Justice Health at any one time. If an inmate was assessed suitable for OST, the inmate's commencement on that therapy would depend on the cap not being exceeded at that time.
139. The OST No.1, as of 2019 and early 2020, provided that:⁶⁷
- (1) Patients assessed suitable for OST were to be categorised as "*priority access*" (i.e., patients that were pregnant, HIV positive, or had Hepatitis B), "*fast track*", or "*pre-release suboxone*".
 - (2) Specifically, in relation to *Pre-Release Suboxone* patients, "[p]atients who do not clinically meet the criteria for priority access or fast tracking may be referred or self-refer to the *Pre-Release Suboxone (PRS)* program if they are sentenced on all

⁶³ <https://www.health.nsw.gov.au/aod/Publications/nsw-clinical-guidelines-opioid.pdf>.

⁶⁴ International Classification of Diseases.

⁶⁵ Diagnostic and Statistical Manual of Mental Disorders (5th Edition).

⁶⁶ Safescript / NSW Health Section 8 permit records.

⁶⁷ OST No.1 (Jan 2019), annexure A to Craig Cooper statement: Vol 8, Tab 250, p. 5.

matters, (have no further court dates) and have a confirmed release date that is no more than 6 months away and have at least 3 weeks of their sentence to still serve at the time of the medical review.”

140. In March 2021, Justice Health issued a revised procedure titled *OAT No.1 – Assess & Commencement of Opioid Substitution Treatment (Revised OAT No.1)*.⁶⁸ This followed the roll-out of Buprenorphine injection as the intended primary medication to be used in the provision of OST or OAT by Justice Health in custody.
141. The key changes provided for in the Revised OAT No.1 were:
- (1) OST was now referred to as OAT.
 - (2) Expanded availability of OAT, with the policy providing that *“all patients entering the correctional system on an Opioid Agonist Treatment (OAT) program are maintained on that treatment unless clinically indicated otherwise.”*
 - (3) Deletion of the *“Pre-Release Suboxone”* program and any express limitation of OAT as regards pre-release inmates. This provided for its general availability to unsentenced prisoners, and sentenced prisoners not nearing release, if assessed suitable.
 - (4) Inmates assessed suitable now fall into two categories only, being *“priority access”* and *“routine application”*.
142. The roll-out of Buprenorphine replaced the provision of Suboxone wafers, with methadone continuing to be prescribed for a limited cohort (e.g. inmates for whom Buprenorphine treatment is contraindicated).
143. As of 2024, patients diagnosed with opioid dependence in custody may be commenced on long-acting injectable buprenorphine (Buprenorphine). This applies to all correctional centres across NSW, including the PCC. Buprenorphine is now the preferred line of treatment for treating opioid dependence in a correctional setting in NSW, except where there are clear and documented medical reasons why this treatment is contraindicated.
144. Over time, the proportion of OST/OAT patients who receive methadone therapy as opposed to buprenorphine depot injections through Justice Health has shrunk. At present, there are approximately 1700 inmates receiving methadone treatment in custody.

⁶⁸

OST No.1 (Mar 2021), annexure B to Craig Cooper Statement: Vol 8, Tab 250, p. 12.

OAT therapy available at the PCC as of January to April 2020

145. SVCH was responsible for the provision of the OAT at the PCC. SVCH was required to have policies that reflected the minimum expected outcomes/requirements provided for by Justice Health's policies. That included the OST No.1 (and later the Revised OAT No.1).
146. As of January to April 2020, the OAT therapy provided by the SVCH at the PCC was:⁶⁹
- (1) Methadone (an oral liquid) (ingested orally).
 - (2) Suboxone (sublingual wafers) (ingested orally).
147. As of January to April 2020, long-acting depot Buprenorphine therapy had not yet been introduced at the PCC.

SVCH policy concerning assessment and eligibility for OST in 2020

148. SVCH had a policy concerning drug and alcohol treatment of inmates in custody, including OST, being *SVCH Policy 6.06 Drug and Alcohol Service (SVCH DOA Policy)*.⁷⁰ The SVCH DOA Policy relevantly provided:⁷¹
- (1) *Assessment:* Information on the RSA formulates key decisions about the most effective treatment plan to support the Custodial Patient through any anticipated drug withdrawal. Referral to appropriate treatment and rehabilitation services should be initiated, which may include referral to the AOD team and medical officers. This will provide ongoing support to the Custodial Patient to assist them in positive decision-making processes and long-term abstinence and/or harm minimisation from substance use ([4.2]).
 - (2) *Monitoring and treatment:* Custodial Patients will have regular scheduled review appointments with the AOD Team (Nursing, medical officer and/or Addiction Specialist). There will be a review of prescription medication at periodic intervals. A management plan will be developed in partnership with the Custodial Patient. This may include counselling, motivational interviewing, and/or brief intervention depending on the Custodial Patient's remand/sentence status ([4.3]).
 - (3) *Opioid treatment program:* The SVCH Opioid Treatment Program (**OTP**) service will operate 7 days per week under the specialist care of the AOD team. The AOD team are responsible for custodial patient OTP management. The Addiction

⁶⁹ Second statement of Kirsty Johnston: Vol 8, Tab 253, p. 2 [9].

⁷⁰ Statement of Kirsty Johnston Annexure D: Vol 8, Tab 252, p. 30.

⁷¹ A summary of Justice Health's OST procedure is annexed to this overview.

Specialist will provide clinical expertise and supervision for the AOD Team to ensure best evidence practice is undertaken ([4.5]).

149. The SVCH had a policy titled *Policy 6.06a Correctional Health: SVCH Alcohol and Other Drug (AOD) Service Model of Care (SVCH AOD Policy)* that was in use as of 22 April 2020.⁷² The SVCH AOD Policy relevantly provides:
- (1) SVCH clinical guidelines for OTP outline detailed procedures for this program in accordance with the NSW Health Guidelines – Treatment for Opioid Dependence (2018) and JH&FMHN Drug and Alcohol Procedure Manual.
 - (2) *Eligibility and assessment:* an AOD Clinical Nurse Specialist was responsible for custodial patient assessment against specific criteria for suitability and providing ongoing monitoring, testing, and screening.
150. SVCH practice and procedure, as of early 2020 and to present day, did not involve a cap on the number of inmates who could receive OST/OAT at any one time at the PCC. Nor was the provision of OST/OAT limited to sentenced prisoners in the “Pre-Release” phase of their sentence, which is consistent with PCC being primarily a remand centre (most inmates not being sentenced inmates let alone ones at a pre-release phase).
151. All inmates stating that they were on OAT when they are received into any NSW correctional facility must have current treatment details confirmed with the appropriate external health service before the first dose can be administered.
152. It is the responsibility of the receiving centre to ensure that on arrival the patient is reviewed and formally authorised to commence OAT (i.e., the patient has a current prescription and PRU number).
153. If at the time of reception an inmate was not currently receiving formal OAT treatment but was assessed to be intoxicated or in a state of withdrawal or was requesting to commence OAT, that patient was to be assessed and a management plan developed.

PRU information

154. As at early 2020, if a patient reported to the SVCH that he or she had been prescribed OAT in the community, the SVCH’s expectation was that:

⁷² Second statement of Kirsty Johnston Annexure E: Vol 8, Tab 252, p. 35.

- (1) SVCH would call the PRU by phone to confirm/request information regarding prescription of S8 medication including OST/OAT approvals for a patient.⁷³
 - (2) Assuming the PRU had records for a specific inmate, the SVCH's expectation would be that the SVCH would receive information including the patient's name, identifying information, S8 prescription(s), and any related dispensing or dosing information.⁷⁴
155. SVCH was not informed that Michael had been approved for buprenorphine treatment in January 2020 or that he had subsequently been exited from the program by the Denison St Clinic on 5 February 2020.⁷⁵ SVCH had no information which indicated a need to contact the PRU at that time in regard to Michael.

Amendment of Michael's priority for Drug and Alcohol Assessment on 2 March 2020

156. On 2 March 2020, Michael was booked for a review by the Drug and Alcohol Nurse. That review was cancelled with the reason recorded that a more urgent appointment required priority. That same day, the Drug and Alcohol Clinical Nurse Specialist (James Cooke) amended Michael's waitlist entry from "*Priority 2 – semi urgent*", which had been assigned by RN Bastola (RSA nurse) on 28 February 2020, to a "*Priority 3 – Non Urgent*".

1st self-referral form completed on 3 March 2020

157. On 3 March 2020, Michael completed a SVCH self-referral form requesting review by a nurse stating:⁷⁶ "*Touch ache – nerve pain. Broken leg = pain. SRT medication from street*".

Review by a Primary Health Nurse on 5 March 2020

158. On 5 March 2020, Michael was seen by a Primary Health Nurse. He was noted to disclose his previous right leg injury which was sighted to be slightly swollen and red. Michael requested to see a GP concerning his pain.⁷⁷

Chronic disease screening on 6 March 2020

159. On 6 March 2020, Michael underwent a chronic disease screening.

⁷³ Third statement of Kirsty Johnston: Vol 8, Tab 253, p.11 [68].

⁷⁴ Third statement of Kirsty Johnston: Vol 8, Tab 253, p.11 [69].

⁷⁵ SafeScript was rolled out in a phased approach from October 2021 and completed statewide by May 2022 (see: <https://www.ehealth.nsw.gov.au/news/2024/safescript-nsw-prescriber-approval-management-function>). It offers a real-time prescription monitoring and approval management system. It allows prescribers and pharmacists to access real-time information about their patient's prescription history for certain high-risk medicines, including opiates. Justice Health have had access to SafeScript NSW since early 2024. Accessing SafeScript NSW was not an option available to the SVCH in 2020 (Third statement of Craig Cooper: Vol 8, Tab 251A, p. 2).

⁷⁶ SVCH Records Black: Vol 7, Tab 249, p. 52.

⁷⁷ Black Justice Health Records: Vol 7, Tab 248, p. 614.

Review by a psychologist on 12 March 2020

160. On 12 March 2020, Michael was seen by Senior Psychologist Andrew Redden (MTC-Broadspectrum) after being referred for risk and possible ongoing psychological assistance. In a statement made for the inquest proceedings, Mr Redden stated:⁷⁸

- (1) The assessment took place in Michael's housing wing in Area 5.
- (2) Michael was referred owing to a reported suicide attempt by Michael around the time of the incidents that led to his return into custody.
- (3) Michael presented in assessment as broadly stable with no evidence of suicide risk (he denied suicidal thoughts). His mood appeared unremarkable and he engaged appropriately although he provided limited details about his mental health history.
- (4) Michael reported being frustrated about his return to custody and adjusting to prison life/environment.
- (5) Michael reported "scant recollection" of any suicide attempt or the matters that led to his return to custody, which he (Michael) attributed to his drug use at the time of his arrest.
- (6) Michael's "*most pressing need and focus of his attention was inclusion in the opiate substitution program*" and he advised he had already been referred to SVCH for assessment for that therapy.
- (7) Although Michael did not express a wish for ongoing psychological support, "*his antecedents merited ongoing monitoring and the referral was maintained for this*".

Michael is charged with misconduct/enters segregation on 12 March 2020

161. On 12 March 2020, Michael was charged with an institutional misconduct offence of "*Serious assault on another inmate*". Michael was one of three persons identified/suspected of being involved in that assault. That inmate was assessed by a nurse and found to have puncture wounds to his body.⁷⁹ That same day, an initial 14 day order was approved by PCC Governor Paul Baker.⁸⁰ Michael was placed in segregation (out of mainstream population).

⁷⁸ Statement of Andrew Redden: Vol 8, Tab 254, p. 2 [7]-[10]; see also OIMS 12.3.2020: Vol 3A, Tab 183, p. 281.

⁷⁹ Black segregation records: Vol 9 Tab 256, p. 219.

⁸⁰ Black segregation records: Vol 9 Tab 256, p. 216.

162. Michael was seen by a nurse daily for general wellness checks as mandated by segregation policy. Brief notations were recorded upon his daily checks.

2nd self-referral form completed on 15 March 2020

163. On 15 March 2020, Michael completed a second self-referral form in which he listed his reason for seeking the review as:⁸¹

"I need to see AOD and psychologist... I don't know what's going on with my medication. I can't sleep, can't relax. My mind is in another place. I walk laps all day with a broken leg. So stressed I can't sit down. I need my medication urgently as I've been asking since I arrived here and am in pain and it's getting worse. Thank you."

3rd and 4th self-referral forms completed on about 15 March 2020

164. On 15 March 2020, Michael completed a self-referral form in which he listed his reason for seeking the review as:⁸²

"I seen nurse at reception when I came in about my medication. I was on the bupe program outside and also on mirtazapine (Avanza) for sleeping/depression. I need my medication. I can't sleep without it and have been going mental waiting to see a doctor. I'm in pain with a broken leg and toothache. Need attention. Thank you"

165. That same day he completed another self-referral form, stating:

"My toothache is killing me. I can't eat, drink, sleep. The whole side of my face/head is hurting, throbbing. I have a headache. I'm going mental and need pain killers until I see the dentist. I can't wait any longer. I've been suffering for weeks now and it's only getting worse. Thank you for listening."⁸³

Review by a Primary Health Nurse on 22 March 2020

166. On 22 March 2020, RN Santosh Sharma saw Michael in the segregation area for a welfare check. Michael was noted to complain of a toothache for which he was provided paracetamol.⁸⁴

Michael completes 5th self-referral form on 25 March 2020

167. On 25 March 2020, Michael completed another self-referral form stating:

"I am sick! Having trouble with everything. Can't rest. Can't sleep. In pain. HELP. Need urgent"

Michael completes 6th self-referral form on 26 March 2020

168. On 26 March 2020, Michael completed another self-referral form that stated:

⁸¹ SVCH Records Black: Vol 7, Tab 249, p. 57.

⁸² SVCH Records Black: Vol 7, Tab 249, p. 58.

⁸³ SVCH Records Black: Vol 7, Tab 249, p. 59.

⁸⁴ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, p. 6 [32].

“AOD: need to get back on the methadone or bupe program. I was on it when I came in three weeks ago. I have asked several times to see someone. Also I was on (Avanza) Mirtazapine for depression/sleeping.

Psych: Institutionalised. Don't know where my mind's at while I walk laps all day with a broken leg, can't relax. Going crazy in pain all day and night between these three issues.

Tooth: toothache nerve pain scale of 1 to 10, 10. Ongoing issue for weeks need something stronger than Panadol. Filled out form for stronger medication weeks ago until seen by dentist still waiting!

Broken leg still in pain. I broke both tibia fibia 3 months ago and still swollen and in pain. Scale 1 to 10, 6.

Overall summary: I need to get on the methadone or bupe program. I'm sick hanging out. Can't sleep/rest, diarrhoea. Shooting up after people. Using dirty [fits?], need a blood test. In pain tooth killing me. I shouldn't have to live like this. I was prescribed medication on the outside. Where is the duty of care.

*Thank you”.*⁸⁵

Review by a Primary Health Nurse on 27 March 2020

169. On 27 March 2020, Michael was seen in the segregation area by RN Kim Alexander. RN Alexander noted that Michael had been a “*PRI – segregation walk in patient*”.⁸⁶ Michael was noted to complain of dental pain for the preceding two or more weeks. RN Alexander also noted:⁸⁷

“Several appointments have been made by the dentist to see the patient. Dentist agreed to see the patient today, segregation notified of this. Segregation contacted second time to remind dentist will see patient today. Patient not brought to main clinic. Next appointment for 15 April 2020.”

170. In a statement prepared for this inquest, RN Alexander stated that based on the records and her experience:⁸⁸

- (1) She expects she spoke to the dentist or the dental assistant to ask if they could review Michael that day. JHeHS note indicates that the dentist agreed to fit Michael in for review that day.
- (2) The dentist works from the Main Clinic only.
- (3) She expects she then contacted the MTC officers stationed at segregation to ask them to arrange to bring Michael to the clinic, as SVCH staff are not authorised to move patients.
- (4) At some point, she realised that Michael was not brought up from segregation by COs, which is why she noted contacting COs in the segregation area a second time to remind them of the availability of a dental review.

⁸⁵ SVCH Records Black: Vol 7, Tab 249, p. 61.

⁸⁶ Statement of Kim Alexander: Vol 8, Tab 254C.

⁸⁷ Black Justice Health Records: Vol 7, Tab 248, p. 626.

⁸⁸ Statement of Kim Alexander: Vol 8, Tab 254C, [13]-[16].

- (5) Owing to Michael not being brought to the Main Clinic that day, RN Alexander assumes, based on what is recorded in the SVCH records, that the next available dental appointment was booked Michael which was 15 April 2020.
- (6) RN Alexander is not aware what the reasons for COs not being able to bring Michael to the Main Clinic that day.

Michael's segregation is reviewed/extended on 26 March 2020

171. On 26 March 2020, Michael's segregation was reviewed. The review recommendation was for the segregation direction to be extended by up to three months (including 14 days) due to the serious nature of the assault.⁸⁹ The extension was supported by Mr Baker and approved by Terry Murrell, Director of Custodial Operations.

7th self-referral form completed on 28 March 2020

172. On 28 March 2020, Michael completed another self-referral form that stated:

"I need to get back on the methadone or bupe program and I also need my other medication Mirtazapine for depression/sleeping. I was on both these medications when I came in at the start of this month. I've been asking everyday. On top of this I'm in pain. Broken leg and toothache. The only way to help if you don't help is to start using dirty jail drugs and needles. Thank you for listening".⁹⁰

Scheduled nurse review does not proceed on 29 March 2020

173. On 29 March 2020, RN Revasayi Mutede assessed Michael's 7th self-referral form and booked an appointment for him to be seen that same day by a Primary Health Nurse for a welfare check/consultation.⁹¹
174. The relevant PAS entry made by RN Mutede recorded "*PRI Acute Consultation*" and "*Self referral. Complaining of too much unspecified pain and requesting for urgent assistance. Please conduct a welfare check*" (assigned "3-Non Urgent" priority).⁹²
175. There is no record of Michael being reviewed as had been scheduled by RN Mutede.
176. In a statement completed for this inquest, Kirsty Johnston, Acting SVCH Nurse Manager at the PCC:⁹³

⁸⁹ Black segregation records: Vol 9, Tab 256, pp. 219-220.

⁹⁰ SVCH Records Black: Vol 7, Tab 249, p. 62.

⁹¹ Statement of Revasayi Mutede: Vol 8, Tab 254G, [10]-[11].

⁹² Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, pp. 7-8 [42]-[47].

⁹³ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, pp. 7-8 [42]-[47].

- (1) Ms Johnston determined, by reference to the PAS, that the request for Primary Health Nurse was scheduled under a specific clinician (RN Zeenat Panjwani) rather than through a generic primary health clinic code (e.g. 'Parklea, Nurse').
- (2) In Ms Johnston's view, a specific nurse rostered to perform primary health nursing duties would likely check the list of patients booked to be reviewed under the generic primary health clinic code but would be unlikely to check for patients specifically booked under her or her name.
- (3) RN Panjwani likely did not realise that Michael was booked to be specifically reviewed by her and this may explain why he was not reviewed at the clinic.

8th self-referral form completed on 8 April 2020

177. On 8 April 2020, Michael completed another self-referral form that stated:⁹⁴

"I need to get on the bupe or methadone program. I was on it on the outside. I've been using in jail for a month now and have been using needles and doing whatever it takes to get drugs. I shouldn't have to do this for a drug. I was prescribed on the outside. I've been doing sexual favours, violence, anything to get my medication. Also I'm on Avanza. I'm in pain. I've got a broken leg and dental issues. I'm going to end up killing someone. I need help URGENT."

Entry into PAS on 9 April 2020 for a review by a Drug and Alcohol Nurse

178. Entries in PAS show that a Drug and Alcohol Clinical Nurse Specialist scheduled a review of Michael for 15 April 2020 in the Drug and Alcohol Nurse Clinic. This appointment was categorised as "priority 3 – non-urgent".⁹⁵

Entries into PAS for Mental Health Nurse review on 8 and 9 April 2020

179. Entries in PAS record Michael being seen in segregation on 8 and 9 April 2020 by a Primary Health Nurse (RN Christopher Joseph) with the notes: "*Seen in Segro – Nil issues*" and "*Segro check*".⁹⁶ In the view of Ms Johnston, these attendances were likely "wellness checks" which are routinely performed each morning in segregation.

180. On 8 April 2020, RN Joseph entered Michael into PAS for a Mental Health Nurse review. This appointment was subsequently cancelled in PAS by RN Thanh Nhi Tran Le on 16 April 2020, who that same day (16 April 2020) re-triaged Michael on the mental health waitlist as a "*Priority 3 = Non Urgent*".⁹⁷

⁹⁴ SVCH Records Black: Vol 7, Tab 249, p. 63.

⁹⁵ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, p. 9 [56]-[57].

⁹⁶ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, pp. 8-9 [53]-[55].

⁹⁷ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, p. 8 [49]-[52].

181. On 9 April 2020, a RN again entered Michael into PAS for a Mental Health Nurse review. This was cancelled that same day by RN Govero Maposa.⁹⁸
182. There is no record of Michael being seen by the Mental Health Nurse on either 8 or 9 April 2020 or on 16 April 2020 when the PAS appointment priority was amended.

Lifting/revocation of the segregation direction for Michael on 9 April 2020

183. On 9 April 2020, Michael's segregated custody direction was revoked after an offence-in-custody hearing took place regarding his involvement in the 12 March assault. As a result of the hearing, Michael was reprimanded with 56 days off buy ups. Michael had spent a total of 29 days in segregation. The minutes of the SRC committee notes that the segregation direction was revoked as a result of the outcome of the offence in custody hearing.

Michael reportedly assaults inmate on 9 April 2020

184. On 9 April 2020, Michael was recorded in a case note report as attempting to assault another inmate when leaving segregation "*in an attempt to have his s.10 segregation order reinstated*".⁹⁹ A subsequent segregation direction was not made and Michael returned to the mainstream population.

Scheduled review with Drug and Alcohol Nurse on 15 April 2020

185. On 15 April 2020, Michael's appointment for review by a Drug and Alcohol Nurse, noted to be for "OST", which had been scheduled on 9 April 2020, was cancelled. The recorded reason for the cancellation was "*Cancelled by DCS*". In the view of Ms Johnston, this indicates that Michael was not brought to the clinic by PCC Correctional Officers (she is unable to comment on the reasons for that).¹⁰⁰

Michael is seen by a Primary Health Nurse on 21 April 2020

186. On 21 April 2020, Michael attended a "*PRI Acute Consultation*" with Primary Health Nurse Divinia Velasco. This appointment was entered or scheduled in PAS the previous day, 20 April 2020. PAS records that Michael attended on 21 April 2020 and was seen by RN

⁹⁸ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, p. 8 [49]-[52].

⁹⁹ Black CSNSW Case Notes: Vol 3A, Tab 183, p. 286.

¹⁰⁰ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, p. 9 [56]-[57] and evidence of Kirsty Johnston: Day 5, T416.1-9, T418.4. The reference to the appointment being "Cancelled by DCS" was a dropdown menu item that was the only option in the dropdowns related to the correctional officers. Correctional officers do not cancel medical appointments: Supplementary statement of Wayne Taylor dated 21 February 2025: Vol 3B, Tab 202A, p. 14 [68].

Velasco, however, a search of JHeHS does not show any notes for that appointment. There is no available record of what Michael reported and what was observed on this occasion.¹⁰¹

COVID-19 RESTRICTIONS / SEARCHES

COVID-19 restrictions

187. COVID-19 restrictions at PCC began in mid-March 2020:
- (1) On 17 March 2020, social visits were suspended;
 - (2) On 18 March 2020, group programs were suspended; and
 - (3) On 22 March 2020, rules were put in place regarding the safe movement of inmates between correctional centres and court complexes.
188. Court attendances were directed to proceed either wholly or mainly via AVL which increased the number of inmates on the AVL lists at PCC.
189. As of 22 April 2020, inmate lockdowns and confinement to manage and prevent the spread of COVID-19 had not commenced by 22 April 2020.¹⁰² Neither Michael nor Mr Sheard were confined in their cell because of lockdowns experienced due to COVID-19 restrictions.

Cell searches and personal searches relevant to Michael and Emmett Sheard

190. MTC-Broadspectrum Policy 4.05 (v 3) (Searching)¹⁰³ provided for the searching of inmates and cells.
191. The MTC-Broadspectrum policy mandated that a minimum of 6 cells within each area were to be searched each day. The cells to be searched were selected randomly by the OIMS search module. In addition, targeted searches can be conducted.
192. From 2 September 2019 until 22 April 2020, Mr Sheard was subjected to 20 personal and cell searches at the PCC.
193. Between 28 February and 22 April 2020, Michael was not subject to any cell or targeted searches at the PCC.

¹⁰¹ Fourth statement of Kirsty Johnston: Vol 8, Tab 253A, pp. 9-10 [58]-[59].

¹⁰² Statement of Wayne Taylor: Vol 3B, Tab 202, p. 6.

¹⁰³ MTC-Broadspectrum Policy 4.05 Searching (v 3): Vol 5, Tab 223.

EVENTS ON 22 APRIL 2020

Reception Area

194. PCC reception area is where inmates were transferred in and out of PCC along with fresh custody inmates.¹⁰⁴

Holding yards/cells and numbers of inmates

195. The Reception Area had two main components, being:

- (1) Holding cells (also known as holding yards); and
- (2) The Processing Area.

196. AVL suites were located on second level in the Reception Area building. The AVL area could be accessed via stairs through the Reception Processing Area.

197. Accessed off a main corridor were 13 holding cells of varying size.

198. On 22 April 2020, cells 9, 12, and 13 were not in use owing to broken lighting, which was being repaired by maintenance workers. Cell 10 was used as a dry cell, as it had no toilet or running water, and was only used to hold one inmate.

In cell CCTV cameras/monitoring station within the Processing Area

199. Each holding cell had an internal CCTV camera (visual only).

200. Monitoring screens, which provided views from those cameras, were positioned on a desk located within a “U-shaped” bench area and in the Centre’s Base unit.

201. As of 22 April 2020, a MTC-Broadspectrum Governor’s instruction (issued September 2019) stated:¹⁰⁵

- (1) Reception cells were to be monitored by staff by way of CCTV.
- (2) Regular welfare checks are to be conducted on Reception inmates at irregular times by reception staff.
- (3) Welfare checks are to be recorded in the Reception logbook.

¹⁰⁴ CO Nathan Attard provided a statement which detailed the PCC reception area as at 22 April 2020; Statement of Nathan Attard: Vol 1, Tab 23, p. 1 [5]-[6].

¹⁰⁵ Protocol at Vol 5, Tab 240.

202. Neither the COPP nor this Governor's instruction mandated continuous monitoring of the CCTV monitors/cameras within the cells.

Reception area layout

203. The layout within the relevant parts of the Reception Holding area as at 22 April 2020 is depicted in the diagram found at Tab 191, Vol 3B.

Searches

204. As of 22 April 2020, MTC-Broadspectrum's procedures concerning the searching of inmates was governed by MTC Broadspectrum Policy 4.05 (v 3) (Searching)¹⁰⁶ and MTC-Broadspectrum Governor's written instruction - *Searching* (May 2019) (**Search Instruction**).¹⁰⁷

205. The Search Instruction provided:

"Effective immediately, all inmates exiting accommodation areas for internal/external escorts - which includes but is not limited to property runs, medical appointments, visits, AVL, court will be screened using a handheld metal detector and pat searched.

Hand-held wands have been issued to all respective areas. See your Area Manager or Supervisor if you require further training or instruction."

206. As of April 2020, CSNSW COPP 17.1 concerned the conduct of searches on inmates within CSNSW operated prisons. The COPP was available to staff on MTC-Broadspectrum's intranet and its terms were generally known to MTC-Broadspectrum COs working at the PCC. COPP 17.1 provided:

"Correctional officers must not pat or strip search inmates of the opposite sex, except in exceptional circumstances or emergencies. Approval must be sought from the Governor or delegated officer if this is to occur."

207. The operation of COPP 17.1 at the PCC was qualified by means of POP 4.05. As of April 2020, MTC Broadspectrum POP 4.05 addressed searches of inmates within PCC.¹⁰⁸ POP 4.05 provided: *"Female correctional officers MAY 'pat' search male inmates"*.

Movement of inmates to/from the Reception Area

208. On the morning of 22 April 2020, 121 inmates¹⁰⁹ were brought from accommodation areas to the Reception Area to enable their access to the AVL suite for Court appearances or legal visits.¹¹⁰ These inmates were placed in holdings cells 1 to 8 and 10 to 11.

¹⁰⁶ MTC-Broadspectrum Policy 4.05 Searching (v 3): Vol 5, Tab 223.

¹⁰⁷ MTC-Broadspectrum Instruction – Searching (May 2019): Vol 5, Tab 241.

¹⁰⁸ MTC-Broadspectrum Policy 4.05 Searching (v 3): Vol 5, Tab 223.

¹⁰⁹ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [10], [13]-[15].

¹¹⁰ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [10].

209. Michael was housed in Area 5B and Mr Sheard was housed in Area 5C.
210. COs Luke Everett and Tori Welsh were responsible for escorting inmates from Area 5 to the Reception Area. Both COs were rostered on as “Rovers” for Area 5, which entailed moving inmates between different Areas of PCC.
211. Inmates were let out of Area 5 at around 8:30am. COs Everett and Welsh waited for the inmates in the Area 5 chute. As the inmates entered the Area 5 chute, CO Welsh marked their names off on a copy of the Area 5 AVL list. CO Everett was standing at the other end of the Area 5 chute.
212. Once all of the inmates were accounted for and marked off the AVL list, the COs closed the gate from the wings and opened the gate at the other end of the chute.
213. COs Everett and Welsh then walked the inmates from Area 5 to Reception.
214. CO Welsh said that the movement was orderly and without incident.¹¹¹
215. Upon arrival at Reception, COs Everett and Welsh were directed by an AVL staff member to place the inmates into holding Cell 4.

Placement in Cell 4 at about 9:30am to 9:40am

216. Between 9:37 and 9:39am, Michael, and other inmates including Mr Sheard, Luke Welford, Matthew Bennis, and Paul Harris, were placed in Cell 4.¹¹²
217. Neither Michael, Mr Sheard, nor any of the other inmates with them at the time were searched on their arrival at the Reception Area before they were placed in Cell 4.
218. In total, 18 inmates (including Michael) were in Cell 4 that morning and were in that cell when the two violent incidents occurred (outlined further below).¹¹³
219. According to CO Welsh in her statement, on arrival she *“told the AVL staff there were way too many inmates to be placed into the one holding cell. The AVL officer responded that that was the only holding cell available. I saw that a number of holding cells were locked off with maintenance workers doing some work in those cells.”*

¹¹¹ Statement of Tori Welsh: Vol 1, Tab 66B.

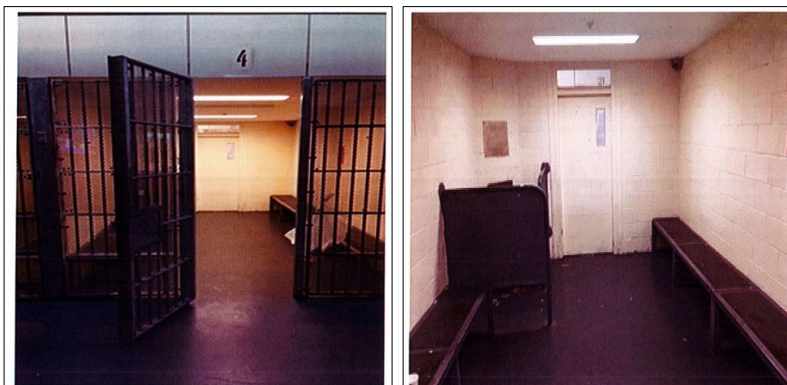
¹¹² Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [16], [18].

¹¹³ Inmates listed in Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [16].

Cell 4 set up/dimensions

220. Cell 4 was about 5 metres by 3 metres in dimension.¹¹⁴

221. Images of Cell 4 on that day include:¹¹⁵



222. The internal camera in Cell 4 can be seen in the second image at the top rear right hand corner.

223. At the end of the cell with the solid entry door was a toilet which was bordered by metal screens.

Holding cell capacity limits

224. It appears as of 22 April 2020 there were no specified limits as to the number of inmates that could be placed in the Reception Area holding cells including that for Cell 4.

225. An MTC-Broadspectrum Risk Assessment Worksheet, approved on 10 July 2020 (after Michael's death), specifies factors to be considered when determining the safe operating capacity of reception cells. That document indicates that cells 2 to 5 have a safe operating capacity of up to 10 inmates.¹¹⁶

226. It is understood an equivalent risk assessment procedure did not exist as of 22 April 2020.

227. As at March 2025, MTC-Broadspectrum specifies the safe operating capacity of cell capacity for Cell 4 to be up to 14 inmates (maximum) based on the fixed seating capacity installed in the Cell.

¹¹⁴ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [11]; Statement of Crime Scene Officer Catherine Evans: Vol 2, Tab 172, [25].

¹¹⁵ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6.

¹¹⁶ Risk Assessment Worksheet: Vol 5, Tab 218, p. 2.

How inmates came to be allocated to the various holding cells

228. Inmates transferred within PCC into Reception on the morning of 22 April 2020 were allocated to cells by reference to their designation or protection status, which included: one Protection Limited Association (PRLA) inmate; one Protection Non-Association (PRNA) inmate; one Special Management Area Placement (SMAP) inmate; three inmates transferred from the Main Clinic observation cells; one segregated custody inmate; two inmates had recently been medicated; and one inmate who refused to be placed with other inmates due to a recent medical procedure. Separation needed to be maintained between these inmates as well as the balance of the inmates awaiting their AVL listings.¹¹⁷ It is unclear how it was decided who would go into what cells in the Reception Area on 22 April 2020.

Covering of Cell 4's internal CCTV camera at 11:31am

229. At about 11:31am, Mr Harris covered Cell 4's CCTV camera with wet toilet paper.¹¹⁸
230. In a subsequent statement made to police, Mr Harris said he did this at Michael's request to "cover the camera", a request usually made when people want to smoke a cigarette or smoke 'bupe'.¹¹⁹
231. A synopsis of events captured by the Cell 4 CCTV camera, including the comings and goings from the cell, between 8:55am and 11:31am is at Tab 101, Vol 1.
232. This camera remained covered until after Michael's removal from the cell after his fatal stabbing at about 12:15pm. Events in Cell 4 after 11:31am were not captured on this camera.

Other inmate movements in the Reception Area at about mid-morning

233. An MTC-Broadspectrum Remedy Report, completed after Michael's passing, relevantly noted that on 22 April 2020:¹²⁰

"The Reception was particularly busy that day with AVL inmates and with transfers. Prior to 11:30am, Reception staff would have been processing 27 inmates that were being transferred out of the Centre....A truck arrived at 11:30am with 15 transfers in (from another CC)...At the same time as receiving the 15 transfers in, Reception staff at 11:40am placed 14 inmates on a DCS truck to be transferred out...." (p.3).

...

¹¹⁷ Statement of Wayne Taylor dated 16 September 2024, Vol 3B, Tab 202, [59]-[60].

¹¹⁸ Detective Sergeant David Lawler, in his review of the CCTV, notes that at 11:30am inmate Sinnathamby handed Michael a toilet role, who then kicked it towards inmate Sinnathamby. Mr Harris picked it up and placed it over the camera (Fourth Statement of Detective Sergeant Lawler: Vol 1, Tab 6, p. 9 [18]).

¹¹⁹ Statement of Paul Harris made 28 April 2020, Vol 1, Tab 67, [6].

¹²⁰ Remedy Report, Vol 2, Tab 130, p. 3.

“CCTV camera in cell 4 had been covered by an inmate in cell 4...and remained covered, and undetected by Reception staff, for a period of approximately 40 minutes. It appears that with the numerous activities that were occurring in a busy Reception that cell 4 was not monitored via the CCTV camera by Reception staff over this period so as to be able to detect the camera had been covered” (p.3).

Luke Welford leaves Cell 4 between 11:57am and 12:06pm for Suboxone

234. At 11:57am,¹²¹ Mr Welford was escorted from Cell 4 to the clinic to receive prescribed Suboxone (sublingual wafer).
235. As of April 2020, the administration of methadone and Suboxone to patients at the PCC was supervised. The supervision requirements were set out in *SVCH Opioid Treatment Program OST Medication Dosing Procedure (OST Dosing Procedure)*. This procedure describes the steps to be taken to mitigate the risk of a patient not ingesting their OAT/OST.¹²²
236. At 12:06pm, Mr Welford was escorted back and re-entered Cell 4.¹²³
237. According to CO Gail Hullett, Mr Welford was suspected of wanting to “divert” his Suboxone dose on this date.¹²⁴
238. In a statement made to police after 22 April 2020, Mr Harris stated that after Mr Welford’s return to the cell, he (Mr Harris) saw Mr Welford take the Suboxone (wafer) out of his mouth with a plastic fork. Mr Welford placed it in an instant rice packet. Mr Sheard assisted Mr Welford in the Suboxone’s removal. This was done at the back of the cell where the toilet was located.¹²⁵

First violent encounter commences shortly before 12:10 pm

239. Shortly before 12:10pm, a violent exchange unfolded within Cell 4 involving Michael and Mr Sheard.¹²⁶
240. The actual events were not directly captured in any recording (CCTV or otherwise).
241. There was no dispute at trial that Michael made a demand of Mr Welford for the diverted Suboxone wafer.

¹²¹ See Chronology of corridor cameras: Vol 1, Tab 100.

¹²² Professor Lintzeris reports that *“the diversion of sublingual buprenorphine has been a problem in its use in prison settings. The concern is that patients can remove buprenorphine tablets or film from their mouths before the medication had dissolved, and the medication can subsequently be used by the person at a later date or supplied to other people to use”*.

¹²³ See Chronology of corridor cameras: Vol 1, Tab 100.

¹²⁴ Statement of Gail Hullett: Vol 1, Tab 52, [9].

¹²⁵ Statement of Paul Harris: Vol 1, Tab 67, [6]-[7].

¹²⁶ This timing is taken from the corridor CCTV camera, which in the OIC’s view shows some altercation in Cell 4 at 12:07:51pm (not a full view of it): Fourth Statement of Detective Sergeant Lawler: Vol 1, Tab 6, [30].

242. What exactly transpired in this encounter was in dispute in the trial.
243. In his written statement made the day after the event, Mr Harris stated he saw Michael strike Mr Sheard.¹²⁷ Mr Sheard suffered a black eye and other injuries. Mr Harris made no mention, in his statement, of seeing Michael holding or using a shiv during the first exchange. However, at trial, issues arose with the reliability of Mr Harris' evidence.
244. At trial, Mr Sheard gave evidence that he was cut under his chin with a shiv by Michael during this encounter (the Crown contended Michael did not use a shiv at this time).
245. Whatever occurred, the Crown's case (at trial) was that Michael overpowered Mr Sheard during this incident.¹²⁸

Attendance of CO Aimee Flynn and Supervisor David Palavi at about 12:11 pm

246. CO Attard initiated a Centre Emergency Response Team (**CERT**) call which was broadcast by way of radio broadcast.
247. By about 12:10:58 pm,¹²⁹ CO Aimee Flynn (Area Manager) had made her way to Cell 4 and was standing in front of Cell 4 looking into the cell.
248. At about 12:11:11 pm,¹³⁰ Correctional Supervision David Palavi joined CO Flynn in this area.
249. Between about 12:11:32 and 12:11:49 pm,¹³¹ CO Mark Hurlstone and CO Nathan Attard (Reception COs) attended that area.
250. At trial, CO Flynn gave evidence that:¹³²
- (1) She was in the Reception Room when she heard the CERT broadcast.
 - (2) She headed straight to Cell 4.
 - (3) As she approached, she heard "*loud noises, so screaming back and forth between the inmates*" in Cell 4.
 - (4) She attempted to assess what was happening within the cell.

¹²⁷ Statement of Paul Harris: Vol 1, Tab 67, [6].

¹²⁸ Summing Up: Vol 2, Tab 159. In summing up, Justice N Adams said "Mr Black attacked Mr Sheard the first time" and it was "pretty common ground ... between the Crown and the defence that it was Mr Black who won that first fight so Mr Black was able to overpower Mr Sheard the first time".

¹²⁹ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³⁰ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³¹ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³² Trial transcript T437-440.

- (5) She was unsure how many inmates were in the cell at the time and agreed "*it was very crowded*".
- (6) She told the inmates in the cell to "*take a seat separate move to the sides what's going on*"?
- (7) Many inmates appeared agitated and aggressive, with there being "*just a lot of shouting back at me, disobeying directions basically saying that nothing was happening, and just to give like lunch out and just to go away*".
- (8) Supervisor David Palavi was with her and he pointed Mr Sheard out to her, at which point she noticed Mr Sheard had bruising and redness to his right eye.
- (9) She requested Mr Sheard to come to the front of the cell for assessment but he refused shouting "fuck off", turning his back to her and ignoring her requests.

Arrival of IRT members in the corridor at about 12:12pm

251. Shortly after midday, IRT members were in the IRT office. The office is separate to the Reception Area Building. IRT members heard the CERT broadcast concerning an inmate fight in the Reception Area.
252. The five member IRT made their way to that location being:
 - (1) Correctional Supervisor Wise Lagilevu.
 - (2) CO Sua "Benny" Fiso (who sometimes held the IRT supervisor role on a given shift however on this date CO Wise Lagilevu was in the supervisor role).
 - (3) CO Samuel Hawthorne.
 - (4) CO Nathan Schwencke.
 - (5) CO Dominic Zinghini.
253. The IRT members wore vests and had other items (e.g., OC spray, handcuffs).
254. CO Fiso and CO Schwenke were the only COs present with Body Worn Video cameras (**BWV**).

255. The IRT members arrived in the Reception Area corridor, near to Cell 4, at about 12:12:03pm.¹³³
256. On arrival, the IRT members were given an update by CO Nathan Attard. At trial, CO Schwenke gave evidence that CO Attard “*explained to us there was a fight in the cell, one of the inmates involved was wearing white 270 Nike shoes*”.¹³⁴
257. By this point, CO Aimee Flynn (Area Manager) and Supervisor David Palavi were still in front of Cell 4.
258. By about 12:12:30pm,¹³⁵ IRT members then moved towards the front of Cell 4.
259. The positioning of the officers is shown in the following CCTV still (time stamp 12:12:34pm).¹³⁶
260. In the above still, the door to Cell 4 is position on the lefthand side and the open door leading from the corridor into the Reception processing area is on the right hand side.
261. Neither CO Fiso nor CO Schwenke activated their cameras this time.
262. Soon after the IRT members’ arrival outside Cell 4, CO Flynn left the area and headed on foot to the Multi-Purpose Building (she is captured leaving at 12:13:05 pm).¹³⁷ At trial, CO Flynn stated she gave CO Fiso a quick verbal handover before departing.¹³⁸

No sighting of weapons by the COs after the first violent incident

263. The COs suspected there had been a fight in Cell 4 that involved Mr Sheard although none of the COs witnessed this firsthand. At this point in time, none of the COs had sighted anyone in Cell 4 to be holding or using weapons.

Initial IRT member interactions with Mr Sheard

264. The IRT members did not themselves witness the first violent incident. After they approached the front of the cell, their attention was directed to Mr Sheard by reference to his distinctive shoes (white Nike “A270” shoes rather than gaol-issued Dunlop footwear).

¹³³ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³⁴ Trial transcript T184-185.

¹³⁵ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³⁶ Fifth statement of Detective Sergeant David Lawler, annexed stills: Vol 1, Tab 7, pp. 4-10.

¹³⁷ See Chronology of corridor cameras: Vol 1, Tab 100.

¹³⁸ Trial transcript T440.

265. CO Fiso and other IRT members saw Mr Sheard's injured eye. CO Fiso made one or more requests of Mr Sheard to exit his cell, telling Mr Sheard he needed to be seen by medical staff. Mr Sheard refused to exit.¹³⁹

Officers move into the Reception processing area between about 12:13pm to 12:15pm

266. At about 12:13:24 pm,¹⁴⁰ four of the five IRT members moved away from the front of Cell 4, in the corridor, and headed into the Reception Processing Area.

267. At about 12:15:20 pm,¹⁴¹ the last remaining IRT member moved away from the corridor area into the Reception Processing Area.

268. At trial, the COs gave evidence to the effect of:

- (1) Supervisor Wise Lagilevu,¹⁴² CO Fiso,¹⁴³ and CO Zinghini moved to a spot within the U-shaped benched area (near/about CCTV monitor screens).
- (2) CO Schwenke,¹⁴⁴ CO Hawthorne,¹⁴⁵ and CO Shellie Browne¹⁴⁶ were standing inside the Processing Area talking to each other (along with CO Attard). They were about one or more metres within the Processing Area away from the door that led to the corridor (facing on to Cell 4).
- (3) CO Attard, at some points in his evidence, appeared to say he was standing at the door to Cell 4 or in the doorway leading from the processing area into corridor. However, CCTV cameras within the corridor (facing along the corridor) do not capture CO Attard in the doorway or in the corridor immediately in front of cell 4 at this time (it can be concluded from the footage that he would have been somewhere inside the processing area).

Commencement of the second violent incident in Cell 4 by about 12:16:30pm

269. CCTV cameras were positioned within the corridor space. Although some of these captured movements at the front of Cell 4, none of these cameras faced directly into that cell and these cameras did not capture the entirety of what occurred.

¹³⁹ Trial transcript (Suia "Benny" Fiso) T248-249; trial transcript (Wise Lagilevu) T131-132; trial transcript (Nathan Schwenke) T185-186; trial transcript (Samuel Hawthorne) T355; trial transcript (Nathan Attard) T821-22.

¹⁴⁰ See Chronology of corridor cameras: Vol 1, Tab 100.

¹⁴¹ See Chronology of corridor cameras: Vol 1, Tab 100.

¹⁴² Trial transcript (Wise Lagilevu) T150-152.

¹⁴³ Trial transcript (Suia "Benny" Fiso) T250.

¹⁴⁴ Trial transcript (Nathan Schwenke) T186-187.

¹⁴⁵ Trial transcript (Samuel Hawthorn) T356-357.

¹⁴⁶ Trial transcript (Shellie Brown) T535-36.

270. The synopsis of the corridor CCTV camera footage records the following being captured on camera:¹⁴⁷

- (1) 12:16:33pm: a person (Michael) can be seen moving into the front right hand corner of the cell and to get up on the bench in that location.
- (2) 12:15:35 to 12:15:45pm: movement can be seen in the top right hand corner of the cell consistent with Michael standing there and kicking his legs out several times.
- (3) 12:16:36pm: rapid arm movement (by Sheard) can be seen striking out at Michael (at least twice).
- (4) 12:16:44pm: following the second strike Michael clutches the inside of his right thigh with his right hand (no weapon visible in Michael's right hand).

COs in the processing area realise the second violent incident has begun

271. At trial, CO Hawthorne gave evidence that from the position he was standing inside the processing area, he saw:¹⁴⁸

- (1) Mr Sheard stand up from the bench on the left side of the cell in a '*staunch*' like position (fighting stance).
- (2) Very quickly a physical altercation unfolded involving Mr Sheard and another (whom he subsequently realised was Michael).
- (3) He believed he witnessed Mr Sheard throw the first set of punches and Michael "throwing punches back".

272. CO Hawthorne said that within seconds he "*turned to my team and said, 'They are fighting again.'*"¹⁴⁹

273. Other COs in the processing recalled hearing either CO Hawthorne and/or CO Attard call out that the inmates in Cell 4 were "fighting again".

274. The COs then proceeded from their positions towards to Cell 4. CO Fiso said he saw COs reaching for their OC spray as he headed towards the door leading into the corridor and he called out "*hold on*" as he wanted to make an assessment before that was deployed.¹⁵⁰

¹⁴⁷ See Chronology of corridor cameras: Vol 1, Tab 100.

¹⁴⁸ Trial transcript (Samuel Hawthorne) T358-59.

¹⁴⁹ Trial transcript (Samuel Hawthorne) T359.

¹⁵⁰ Trial transcript (Suia "Benny" Fiso) T251, 257 and 308-09.

COs within the Processing Area realising the second violent incident was underway and returning into the corridor in front of Cell 4 by about 12:16:50pm

275. A corridor CCTV camera, at about 12:16:48pm, captured the shadow of a CO (IRT member) appearing on the outside of the side of the doorway to the corridor outside Cell 4 (e.g. doorway adjoining the corridor and Processing Area).
276. A corridor CCTV camera, at about 12:16:55pm,¹⁵¹ captured the first two COs, being CO Schwenke and CO Fiso, enter into the corridor area. This is depicted in the CCTV still (time stamp 12:16:57pm).¹⁵²
277. By about 12:17:15pm, CO Schwenke and CO Fiso had been joined in the corridor area out the front of Cell 4 by IRT Supervisor Wise Lagilevu, CO Zinghini, CO Brown, and CO Attard.¹⁵³

Evidence of COs at trial regarding their observations of Mr Sheard inflicting injuries to Michael

278. Evidence was given at trial by several COs regarding what they witnessed take place inside Cell 4 about the time of the second violent incident. That included:
- (1) Reception COs such as CO Attard and CO Browne.
 - (2) The IRT members, being Supervisor Wise Lagilevu and COs Fiso, Zinghini, Hawthorne, and Schwenke.
279. Simply put, the CO witnesses variously described witnessing:
- (1) Mr Sheard standing in the middle of the cell holding a “shiv” in his right hand and striking out at Michael with it (including impacting).¹⁵⁴
 - (2) The shiv held by Mr Sheard was variously described to be about 20 to 25 centimetres in length and to appear “white/silver/grey sort of colour.”¹⁵⁵
 - (3) When COs reached the corridor area, Michael was positioned in the front right-hand corner of the cell on the bench in a defensive posture.
 - (4) Michael had injuries including to his thigh area and was bleeding.

¹⁵¹ See Chronology of corridor cameras: Vol 1, Tab 100.

¹⁵² Fifth statement of Detective Sergeant David Lawler, annexed stills: Vol 1, Tab 7, pp. 4-10.

¹⁵³ Fifth statement of Detective Sergeant David Lawler, annexed stills: Vol 1, Tab 7, pp. 4-10.

¹⁵⁴ Trial transcript (Samuel Hawthorne) T358-59; trial transcript (Nathan Schwenke) T190-191.

¹⁵⁵ Trial Transcript (Suia “Benny” Fiso) T253.

- (5) Mr Sheard was or came to be in around the centre of the cell and was holding the shiv. He ignored commands yelled at him by COs to drop his weapon.
 - (6) Mr Sheard then moved to the rear of the cell near to the toilet area where COs did not have a direct line of sight.
 - (7) Shortly afterwards, Mr Sheard returned to the centre of the cell in view of the COs but was not seen holding the shiv at this time.
280. Some of the attending CO/IRT members did not witness the actual fighting inside, however, they did see Mr Sheard holding a shiv at that time: e.g. see evidence of Supervisor Wise Lagilevu (fighting was over by the time he reached the corridor)¹⁵⁶ and CO Fiso (fighting over by the time he arrived).

Handheld recording made of events in Cell 4

281. By about 12:17:30pm,¹⁵⁷ Supervisor Wise Lagilevu passed the handheld camera he was holding to CO Browne to continue recording.¹⁵⁸
282. This recording commenced after Mr Sheard had inflicted injuries to Michael.
283. Stills taken from the handheld recording are contained in Tab 109, Vol 1.
284. A transcript of the handheld recording is at Tab 107, Vol 1, which records:
- (1) COs making several requests to Mr Sheard to “drop the weapon” and “*Sheard, Sheard. Hurry up we need a nurse*”.
 - (2) Michael is heard stating several times to the effect “*Get me out of here, please*” and “*I’m going to die here*”.
 - (3) Mr Sheard is heard making several abusive statements including, “*You’re a fucken sick cunt now. Who’s the fucken mad cunt now huh....*”, “*I’ll fucking murder you, you fucking maggot*” and to make other taunts directed at Michael.
285. In the view of Detective Sergeant David Lawler (officer-in-charge), the handheld camera’s footage provides clearer evidence than the body worn footage with the viewpoint of the latter being obscured by the COs’ movements.¹⁵⁹ In his view:¹⁶⁰

¹⁵⁶ Trial transcript (Wise Lagilevu) T134.

¹⁵⁷ See Chronology of corridor cameras: Vol 1, Tab 100.

¹⁵⁸ Fifth statement of Detective Sergeant David Lawler, annexed stills: Vol 1, Tab 7, pp. 4-10.

¹⁵⁹ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [42].

¹⁶⁰ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [42].

- (1) The recording “*started approximately 10 seconds after [Michael] had been...last stabbed by [Mr Sheard]*”.¹⁶¹
- (2) It shows Mr Sheard being ‘*extremely aggressive*’ to Michael, who was standing on the bench seat in the corner.
- (3) It shows Mr Sheard holding a sharp edged weapon in his right hand and a sharp edged weapon (shiv) can be seen on the floor near Michael.
- (4) The footage shows Michael bleeding heavily.

286. A transcript of the handheld recording is at Tab 107, Vol 1.

Removal of Michael from Cell 4 at about 12:17:36pm

287. At 12:17:36pm,¹⁶² CO Fiso opened Cell 4’s door.

288. Michael fell to his backside and shifted over to the cell door. The cell door was opened and Correctional Supervisor Wise Lagilevu grabbed and drag him out of the cell.

289. At about 12:17:41pm,¹⁶³ Supervisor Wise Lagilevu briefly entered the cell and dragged Michael out.

Michael’s possession of a shiv

290. When Michael was removed from the cell, a shiv fell to the ground near him. This shiv is depicted:¹⁶⁴



Fourth statement of DS Lawler (Vol 1, Tab 6, p.14)

¹⁶¹ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [43].

¹⁶² Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [42].

¹⁶³ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [42].

¹⁶⁴ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [45].

291. Supervisor Wise Lagilevu used his foot to push the shiv away and it was later seized. This was captured on a corridor CCTV camera at 12:17:45pm.¹⁶⁵

Treatment provided to Michael at the scene

292. COs shifted Michael around the corner, away from Cell 4, into an adjoining corridor.

293. Michael was bleeding profusely and COs used sheeting and other linen to apply pressure to his wounds.

294. Nurses¹⁶⁶ and Dr Mark Tattersall, a visiting medical officer with SVCH, attended to render first aid to Michael.

295. According to Dr Tattersall, when he arrived he found Michael lying in a pool of blood in the corridor outside the AVL cell. Michael was conscious, agitated, and complaining of pain and that he could not breathe.

296. About five minutes after his arrival, Michael suffered a cardiac arrest. Cardiopulmonary resuscitations were begun by the medical team, which they continued until care was taken over by the retrieval medical team from the Westmead Hospital who arrived there on a Care Flight helicopter.¹⁶⁷

297. Ambulance Service NSW paramedics also attended the PCC to assist.

298. Attempts to revive Michael were unsuccessful and he was declared deceased at the scene by Dr Patrick Liston, a specialist in anaesthesia and intensive care medicine, who was part of the retrieval medical team.¹⁶⁸

Michael's injuries

299. Dr Dianne Little, pathologist, performed the autopsy and completed a pathology report on 24 April 2020.

300. Dr Little identified the direct cause of death was a stab wound to the chest.

301. Dr Little identified a total of 8 stab wounds to Michael's trunk, left arm and right and left leg, the depth of which ranged between 16 to 110mm. Of these:

- (1) Six of these extended only into soft tissue without damaging major blood vessels, being wounds to his upper right back /shoulder; his left proximal upper arm

¹⁶⁵ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [42].

¹⁶⁶ Nurses included Kirsty Johnston (statement at Vol 2, Tab 174); Debbie Young (statement at Vol 2, Tab 175); Janet Binay (statement at Vol 2, Tab 176); Kim Alexander (statement at Vol 2, Tab 177); and Irene Deo (statement at Vol 2, Tab 178).

¹⁶⁷ Statement of Dr Mark Tattersall: Vol 1, Tab 10.

¹⁶⁸ Statement of Dr Patrick Liston: Vol 1, Tab 8.

(posterior aspect); mid-left forearm (radial side); distal left forearm; distal left thigh and distal right thigh and knee.

- (2) One wound to the lower left chest extended through the diaphragm into the stomach but was not considered immediately fatal.
 - (3) The remaining wound entered Michael's chest entering the middle lobe of the right lung.
302. In the opinion of Dr Little, the latter chest wound likely resulted in haemorrhage of blood, possibly from damaged vessels in the chest wall,¹⁶⁹ which resulted in his death.
303. During autopsy Michael was also found to have a syringe (with needle) hidden in the hem of his singlet top.¹⁷⁰

Removal of Emmett Sheard from Cell 4

304. At some point while in Cell 4, Mr Sheard removed his white shoes. Mr Sheard exited Cell 4 wearing socks only.¹⁷¹ Mr Sheard's shoes were provided to Mr Welford who initially wrapped them in a green prison jumper. These were later provided to Mr Bennis who allegedly wore them out of Cell 4 (these were seized from Mr Bennis).¹⁷²

Emmett Sheard's injuries and strikes to self

305. When Mr Sheard was removed from Cell 4, he had a laceration to his chin and two lacerations on his left arm (see photos of lacerations additional to the bruising and swelling to his eye which he was observed to have after the first violent incident).¹⁷³
306. He was treated in a nearby cell by an attending nurse.
307. At trial, there was a dispute as to the exact timing of when his left arm lacerations were inflicted (relative to Michael's injuries) and whether these were inflicted by Mr Sheard himself.

¹⁶⁹ Pathologist report: Vol 1, Tab 2, p. 4.

¹⁷⁰ Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [50].

¹⁷¹ At trial the Crown contended this was done to conceal the blood on them and constituted consciousness of guilt. Mr Sheard admitted giving his shoes to Mr Bennis. He said he did so because he wanted them returned to his Pod, rather than being seized, rather than him wanting to conceal what he had done.

¹⁷² Fourth Statement of Detective Sergeant David Lawler: Vol 1, Tab 6, [76]-[78].

¹⁷³ Fourth statement of Detective Sergeant David Lawler: Vol 1, Tab 6, pp. 19-20 [45]-[46].

308. At trial, the Crown contended Mr Sheard inflicted the wounds to his own arm.¹⁷⁴ This included reliance on the evidence of correctional officers and what was captured in the hand-held video recording.
309. Evidence was adduced at trial from some of the COs present about witnessing Mr Sheard strike or impact his left forearm area.
310. A synopsis or chronology of the hand-held that footage is at Tab 104, Vol 1. This recording commenced *after* Mr Sheard inflicted injuries to Michael using a shiv. The synopsis relevantly set out the following:
- (1) About five seconds into the recording: the inside of Mr Sheard's lower left arm is seen. No injury or blood is visible at this time.
 - (2) About seven seconds into the recording: Mr Sheard strikes the inside of his lower left arm (in the synopsis this is described as "*Sheard cuts the inside of his lower left arm with his shiv - - - No injury or blood visible on the outside or outer edge of Sheard's lower left arm*").
 - (3) About 1 minute 42 seconds into the recording: an injury (blood) is visible on the outside or outer edge of Mr Sheard's lower left arm (visible for the first time). This is after Michael is removed from Cell 4 by officers (about 42 seconds into the recording), and after Mr Sheard moved to the rear of the cell near the toilet area and then returned to the front of the cell without his 'shiv'.
311. Further, the transcript of the audio of the hand-held recording, reveals:¹⁷⁵
- (1) At about two minutes into the recording, Mr Sheard is heard to say, "*Yeah I know my arm*".
 - (2) At about 2 minutes 42 seconds in the recording, Mr Sheard is heard stating "*I got stabbed too brother, I got stabbed too*".
312. Mr Sheard gave evidence Michael caused his left forearm injury with the "shiv" and denied inflicting these on himself.¹⁷⁶

¹⁷⁴ The Crown relied upon the evidence of (1) what Mr Harris had said in his "first version" to police (e.g., Michael did not have a knife to begin with) (*noting it appears issues over Mr Harris' reliability arose during his evidence in the trial*); (2) the evidence of COs Nathan Attard and Samuel Hawthorne's observations to the effect they did not see Michael with a 'shiv' when they approached the cell (although defence contended that CO Hawthorne's statement to police suggested he saw both with 'shivs' in the middle of the cell); and (3) handheld footage made by COs after they attended in response to the second violent exchange.

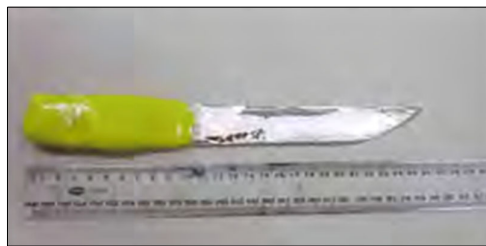
¹⁷⁵ Transcript of audio: Vol 1, Tab 107.

¹⁷⁶ Summing Up 20.7.2022: Vol 2, Tab 159, p. 25.

313. In summing up, Justice N Adams observed “*there [was] no direct evidence...as to how Mr Sheard received those injuries*”. *The Crown [relied] on inferences, to some extent, and indirect evidence [to support its contention]*”.¹⁷⁷
314. In the opinion of the officer-in-charge, expressed in a statement made after trial, Mr Sheard stabbed his own arm *after* stabbing Michael consistent with that seen in the handheld recording.¹⁷⁸

Removal of other inmates from the cell

315. All other inmates were subsequently removed from Cell 4 one at a time and subjected to a search which included a pat down and x-ray screening in the Reception Area.
316. On exiting Cell 4, Mr Welford disclosed to CO Schwenke¹⁷⁹ that he had a weapon on his person. This was retrieved from his pants without issue by the COs. That weapon is depicted:



Fourth statement of DS Lawler (Vol 1, Tab 6, p. 22)

317. DNA matched to PCC inmate Joel Mark Anthony (who was not in Cell 4 at the time) and Mr Welford was on the handle. Michael’s DNA was not located on this knife.

Sheath found in Cell 4 after the removal of inmates

318. A green sheath was found in the cell’s toilet after the removal of the inmates from Cell 4.¹⁸⁰
319. Mr Sheard gave evidence during the criminal trial that he disposed of the sheath that he had used to cover the shiv he was in possession of in the toilet of Cell 4. He said that he did this after the conclusion of the second fight. Upon being shown a photograph of the sheath found in the toilet, Mr Sheard agreed that was the sheath that he had disposed of.¹⁸¹
320. The recovered sheath is depicted:

¹⁷⁷ Summing Up 20.7.2022: Vol 2, Tab 159, pp. 25-26.
¹⁷⁸ Fourth statement of Detective Sergeant David Lawler: Vol 1, Tab 6, pp. 20-21 [68].
¹⁷⁹ Trial Transcript 199.
¹⁸⁰ Statement of Crime Scene Officer Catherine Evans: Vol 2, Tab 172, [26].
¹⁸¹ Trial Transcript 1304.



Fourth statement of DS Lawler (Vol 1, Tab 6, p. 17)

Item found in Cell 1

321. The inmates in Cell 4 were shifted to cell 1 after being spoken to by police. Police later found a goal-made weapon near cell 1's toilet. This was found to have DNA matched to John Bishop (who was not in Cell 4 at the time of the *second* violent encounter).



Weapon found in cell 1

322. In the view of Detective Sergeant David Lawler, the above item was not used in the violent incidents involving Michael and Mr Sheard.

Search of Mr Sheard's cell

323. Several weapons or related items were in Mr Sheard's cell after Michael's stabbing as depicted:



Fourth statement of DS Lawler (Vol 1, Tab 6, p. 24)

- (2) Michael made a demand for that Suboxone.
 - (3) There were two violent incidents in the cell involving Michael and Mr Sheard.
 - (4) During the first violent incident Mr Sheard suffered an injury to his eye (bruising/swelling).
 - (5) During the second violent incident Mr Sheard inflicted wounds to Michael using a “shiv”.
 - (6) That at some point Michael also had a “shiv”.
331. The Crown contended that Michael overpowered Mr Sheard during the first encounter, without a weapon, and Mr Sheard, angry and humiliated, then attacked Michael with a “shiv” with intent to kill or cause grievous bodily harm and when he did so, he was liable for murder. Alternatively, the Crown contended manslaughter was established by way of dangerous and unlawful act owing to excessive self-defence.¹⁸⁵
332. At trial, Mr Sheard disputed the circumstances of the violence exchange. He gave evidence that he acted in self-defence to the effect:
- (1) The first violent incident resulted from Michael’s demand for Mr Sheard to give him “bupe” which he resisted.
 - (2) The second violent incident was initiated by Michael, who he said used a “shiv” as he had not *“got what he wanted from Mr Sheard the first time”*.
 - (3) He (Mr Sheard) did not dispute inflicting the fatal stab wound during the second violent encounter, but maintained he had not aimed at any specific spot and did not have time to think other than *“I have to pretty much stop him or he’s going to kill me”*.¹⁸⁶
333. The jury were directed that it would return a not guilty verdict if it was not satisfied the prosecution had negated, beyond reasonable doubt, that Mr Sheard had acted in self-defence.

¹⁸⁵ Directions on excessive self-defence were (a) if the Crown did disprove that Mr Sheard believed his conduct was necessary, (b) but the Crown did disprove that Mr Sheard’s response (fatal stab) was reasonable in the circumstances as he perceived, he was liable for manslaughter. Summing Up of 21.7.2022, Vol 2, Tab 159, p. 58. The jury were also directed on the defence of “extreme provocation” although her Honour emphasized that was not a defence relied upon by Mr Sheard at trial (Summing Up: Vol 2, Tab 159, p. 59).

¹⁸⁶ Summing Up: Vol 2, Tab 159, pp. 59, 67. Justice N Adams directed in summing up to the jury that the trial, at its essence, concerned whether self-defence was raised and if so could it be negated beyond reasonable doubt by the Crown.

CSNSW INVESTIGATION

334. The CSNSW *Serious Incident Review*, completed on 26 July 2021, concluded:¹⁸⁷

- (1) COs Luke Everett and Tori Welsh did not comply with the PCC policy's requirement to conduct a pat down search of all inmates when escorting them from Area 5 to the reception area (SIR, [137]). Section 1.4 of the *COPP 17.1 Searching Inmates Policy* states that *"All inmates must be searched before and after ANY escort by CSNSW officer or police"*. By cl 46(1)(a) of the CAS Regulation, a CO may, if directed or if the CO considers it appropriate, "search an inmate (including by means of a strip-search or the use of an electronic or X-ray scanning device) and search an inmate's cell and property in the cell" (SIR [150]). In the view of the CSNSW investigator, *"COs Everette [sic] and Welsh failed to conduct pat (or wand searches - handheld electronic metal detector – as required by MTC searching policy) searches of all the inmates, including BLACK and SHEARD, when they were removed from their cells and taken on this escort to the reception/intake holding yard. The evidence gleaned during this investigation has shown that BLACK and SHEARD were armed with gaol made weapons (shivs) and had an appropriate pat search been undertaken, those weapons would have been detected"*.
- (2) Correctional Supervisor Palavi, CO Hurlstone, CO Diane Milner, CO Browne, and CO Attard collectively failed to notice the coverage of the internal CCTV camera in Cell 4 (SIR [135]). That failure was the subject of legislation (SIR [147]). There was a camera monitor screen, in the reception area at the PCC, but the COs in reception failed to detect the camera being covered and, significantly, failed to notice the CCTV monitor screen was blank (this was only realised *after* Michael was stabbed) ([160]). This contravened *COPP 19.3 Video Evidence Policy* and cl 252 (Vigilance) of the CAS Regulation (SIR [174]).
- (3) CSNSW confirmed with the operator of the PCC that it had no policy or local operating procedure for managing the maximum number of inmates allowed in a reception holding cell (SIR [139]).
- (4) The operator's *"Report responding to the DIC of Black, dated 1 May 2020"* noted that a *"risk assessment was to be conducted to determine the appropriate number of inmates to be held in a holding cell"* but at the time there was no policy or procedure guiding this assessment (SIR [142]).

¹⁸⁷ Serious Incident Report dated 26 July 2021: Vol 3A, Tab 175.

335. In his view, Senior CSNSW Investigator John Purcell considered that the following COs contravened relevant CSNSW operating procedures and/or the CAS Regulation:

- (1) CO Everett and CO Welsh contravened *COPP 17.1 Searching Inmates Policy* and cl 46 of the CAS Regulation for failure to pat search inmates (SIR [172]-[173]).
- (2) Correctional Supervisor Palavi, CO Milner, CO Browne, and CO Attard contravened *COPP 13.9 Video Evidence Policy* and cl 252 of the CAS Regulation for failing to notice the coverage of the CCTV camera lens in Cell 4.

END