



CORONERS COURT OF NEW SOUTH WALES

Inquest: Inquest into the death of PF

Hearing dates: 28, 29 April 2024 and 4 and 5 June 2025, Coroners Court, Lidcombe

Date of findings: 24 July 2025

Place of findings: Coroners Court, Lidcombe

Findings of: Deputy State Coroner, Magistrate Hosking

Catchwords: CORONIAL LAW – Mandatory inquest pursuant to s 23(1)(d)(ii) of the *Coroners Act 2009* (NSW) – Death in custody; intentional self-harm following adverse legal advice; in custody identification of risk of self-harm.

File number: 2023/298225

Representation: Counsel Assisting the Inquest: Michael Dalla-Pozza instructed by Agrima Shrestha, NSW Crown Solicitor's Office.

Commissioner of Corrective Services NSW (**CSNSW**): Jonathon Wilcox of Counsel, instructed by Anna Searle, Department of Communities and Justice.

Justice Health and Forensic Mental Health Network (**JHNSW**): Jake Harris of Counsel instructed by Kate Hinchcliffe of Makinson d'Apice.

Findings: **Identity of deceased:** PF

Date of death: Between 17 and 18 September 2023

Place of death: South Coast Correctional Centre

Manner of death: Intentional self-harm while in lawful custody

Cause of death: Hanging

Recommendations: N/A

Publication orders: Non-publication orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Hosking is available upon request from the Court Registry.

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FINDINGS

Introduction

- 1 In accordance with s 75(5) *Coroners Act 2009* (NSW) (**the Act**), and subject to non-publication orders, I make an order permitting the publication of these findings as I find it is in the public interest to do so.
- 2 Section 81(1) of the Act requires that when an inquest is held, the coroner must record in writing their findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.
- 3 In addition, the coroner may make recommendations in relation to matters arising out of the death in question where such recommendations have the capacity to improve public health and safety in the future.
- 4 These are the findings of an inquest into the circumstances of the death of PF at South Coast Correctional Centre (**SCCC**) between 17 and 18 September 2023, aged 45. PF was a much loved son, brother and grandson. PF's mother, father and sister all attended the inquest accompanied by their families. For PF's mother, sadly this is her second coronial inquest. Her eldest son died in a tragic accident aged 3.
- 5 This inquest is held pursuant to the jurisdiction conveyed by s 23 (1)(d)(ii) of the Act in circumstances where at the time of his death, PF was an inmate in a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW).

The issues examined at the inquest

- 6 An inquest into the circumstances of PF's death was held on 28, 29 April and 4 and 5 June 2025 at the Coroners Court at Lidcombe.
- 7 The issues identified in the coronial investigation to be explored in the inquest follow.

- (1) Findings as required by s 81 of the Act.
- (2) Whether PF's mental health was appropriately and adequately managed in custody including consideration of:
 - (a) whether the processes both at MRRC¹ and SCCC² for receiving and transferring an inmate were appropriate?
 - (b) whether sufficient weight was given to PF's history of intentional self-harm?
 - (c) whether proactive steps should have been taken to assess and monitor PF's mental health particularly following the refusal of his bail application and advice from his legal team regarding sentence prospects?
 - (d) whether PF received medication in custody for his mental health? If not, why not?
 - (e) whether PF was accommodated in an appropriate cell?
 - (f) whether PF ought to have been placed on an ISP³ or RIT⁴?
- (3) What was the role of JHNSW and did JHNSW carry out its role in a manner consistent with its own policies and procedures?
- (4) Is it necessary or appropriate to make recommendations?

¹ Metropolitan Remand and Reception Centre.

² South Coast Correction Centre.

³ Immediate support plan.

⁴ Risk Intervention Team management plan.

The evidence

- 8 Tendered to the court was a 5 volume brief of evidence compiled by the Officer in Charge of the coronial investigation, Detective Senior Constable Emily Steele, and supplemented by the Assisting Team.
- 9 At the inquest, the court received oral evidence from:
- (1) Benjamin Smith, MRRC Correction Officer, CSNSW
 - (2) Leesa Smith, Services and Programs Officer, MRRC, CSNSW
 - (3) Benjamin Goodwin, Senior Correctional Officer, SCCC, CSNSW
 - (4) Joshua Medlock, psychologist, Senior Psychologist, SCCC, CSNSW
 - (5) Florencio Cases, Senior Correctional Officer, (then) SCCC⁵, CSNSW
 - (6) Rebecca Wilson, (then) Case Management Officer SCCC⁶, CSNSW
 - (7) Jilane Sarjeant, Primary Health Registered Nurse, MRRC, JHNSW
 - (8) Raymond Hudd, PF's psychologist in the community
 - (9) Garth Shields, Senior Assistant Superintendent (Deputy Manager), CSNSW.

Findings

- 10 As will be seen, I have concluded that:
- (1) While more information could have been obtained from PF during his reception, intake and classification processes as to his history of self-harm, the processes that were undertaken were reasonable having

⁵ Cases now works at John Maroney Correctional Centre.

⁶ Wilson is now an Acting Senior Case Management Officer.

regards to the limited resources and the fact that the officers involved were not psychologists. PF's history of mental illness and history of self-harm was recognised albeit with inadequate detail.

- (2) While the evidence as to whether or not PF's mental health history and history of self-harm was taken into account by the classification placement team (**CPT**) when they determined that PF ought to be placed at the SCCC was inconsistent, there is no evidence indicating that the placement was inappropriate in light of his history of mental illness and self-harm or that it contributed to PF's death.
- (3) In custody PF was appropriately recognised as requiring a high level of psychological support (psych 2) and was engaged with both Medlock and Hudd.
- (4) Tragically, PF was to see Medlock on 13 September 2023, an appointment cancelled because of a Covid-19 lockdown. It is uncertain whether this appointment may have acted as a 'circuit breaker' in respect of what we now know to be PF's deteriorating mental health.
- (5) The evidence does not suggest that additional interventions would have prevented PF's death or that his acute risk of suicide in the days prior to his death was identifiable. As such, save for the fact that PF had been refused bail and then met with his lawyers, there is no evidence of any trigger or 'red flag' which was missed in PF not being placed on an ISP or RIT.
- (6) Adequate inquiries were made with PF in relation to whether or not he required medication to assist with his mental health.
- (7) PF's placement in a 'one out' cell was not inappropriate given it was at his request and the reasons he made that request.

- (8) Justice Health was to respond to referrals made to it by CSNSW. Unfortunately, Hudd did not convey his concerns to CSNSW or contact Justice Health. The evidence adduced indicated that Dr Elliot did follow up with PF regarding his medication needs. There was no evidence adduced which indicated non-compliance by JHNSW with any of its policies and procedures.

Recommendations

- 11 For the reasons outlined below, I did not consider it appropriate or necessary to make recommendations in relation to PF's death.

Background

- 12 I have drawn from Counsel Assisting's submissions in relation to non-contentious factual matters and issues. I am grateful for his assistance.
- 13 PF was born on 23 April 1978. PF's family described a difficult childhood. He lived with his mother, sister and grandparents. PF's behavioural issues and learning difficulties were noticeable from when he commenced kindergarten in 1983. The support that may be available now was not available to PF in the 1980s. It is believed that PF was diagnosed with attention deficit disorder by Dr Serfontein in his early years. He was also later diagnosed with bipolar disorder, anxiety, depression and PTSD in his later years.
- 14 PF's mother describes a trip overseas when PF was 10 as being a happy time for the two of them.
- 15 In 1991, PF was made a ward of the state. This did not assist in PF having access to the behavioural support he needed. PF told his family that he was sexually abused by multiple male teachers and by correctional staff in a juvenile justice centre during this period.
- 16 Both his mother and his sister describe how PF found a job he loved as a long haul truck driver.

- 17 In 2009, PF was devastated by the loss of his grandfather (Nonno).
- 18 On 24 March 2019, aged 40, PF entered custody. This was his first time in custody and he was sentenced to 5 years with a non-parole period of 2 years. He was accommodated first at MRRC and from 15 June 2019, in Junee Correctional Centre. He struggled in custody and his mother was concerned about his declining mental health.
- 19 On 24 May 2019, during his lodgement interview, PF stated that he had attempted suicide 3 months prior and in the 24 hours preceding the interview. He indicated he would probably hang himself. It appears that this disclosure triggered PF being placed on an ISP and an RIT was made in respect of him.
- 20 A Health Problem Notification Form (**HPNF**)⁷ dated 24 May 2019 noted PF was to be placed in an:
- ...assessment cell until cleared by RAIT⁸, detox, minimal clothing, safe blanket
NIL sharps/cutlery.
- 21 That HPNF also instructed correctional staff to look out for the following signs/symptoms:
- 1st custody; MH issues, Active RIT, AOD use...
- 22 A further HPNF, dated 27 May 2019 records 'seen and cleared by detox' and recommended PF for 'group cell placement per RAIT'. It appears from this that the outcome of the RIT process was that PF was discharged into group cell placement.
- 23 On 31 January 2020 PF overdosed on antipsychotic medication and experienced seizure activity. His mother reported that he was in a coma for 6 days. He expressed to his mother that he hadn't wanted to be saved. He was placed on an IRP⁹ until 18 February 2020. His mother reported that shortly after

⁷ This is the form by which JHNSW communicates instructions to custodial staff concerning the health care to be provided an inmate.

⁸ Risk Assessment Intervention Team.

⁹ Interim At Risk Treatment Plan.

this incident, he arranged for a will, a power of attorney and expressed he did not want to be resuscitated.

- 24 On 10 June 2020, a Mandatory Notification¹⁰ records that PF was screened after court given his previous serious suicide attempt. It appears he was placed on a RIT which involved him being placed in a camera cell and remaining under observations until 11 June 2020.
- 25 On 20 July 2020 a Mandatory Notification indicates that PF threatened to 'slash up' after being sentenced to an additional 17 months. He was again placed in a camera cell and subject to observations.
- 26 On 28 March 2022, PF was released on parole. He was living in a granny flat in Minto and returned to his work as a truck driver.

Arrest

- 27 On 25 February 2023, PF was re-arrested. He was refused bail and his parole was revoked.
- 28 He was initially detained in holding cells at Camden Police Station. A custody management record was completed by NSWPF officer, Jeffrey Higgins. Higgins recorded that PF did not make a threat of self-injury whilst in custody. Higgins assessed PF as appearing 'fine' with 'nil issues.' Significantly, Higgins also recorded that PF had advised him that he attempted to overdose approximately a year and a half prior by swallowing 450 tablets. The custody management record further records that PF was taking medication for anxiety, bipolar, schizophrenia and depression and that he 'takes medication daily'.
- 29 While PF may have stated that he was taking medication daily, this was not supported by the evidence. The referral letter from Raby Medical centre to Hudd dated 29 April 2022¹¹ states, 'Current Medications: None recorded' and Raby Medical Centre's Mental Health Treatment Plan also states, 'Not on regular

¹⁰ Mandatory Notification for inmates at risk of suicide or self-harm.

¹¹ Tab 156 P29

meds.¹² It may be that PF was taking daily medication prior to his arrest but that was not apparent based on his available medical records.

MRRC

New Inmate Lodgement & Special Instruction Sheet (NIL&S)

- 30 PF was initially housed in the MRRC. On 26 February 2023, he was interviewed by Benjamin Smith who completed the NIL&S. This form is to address immediate concerns relating to inmates taken in custody.
- 31 Benjamin Smith confirmed he had mental health training. When interviewing an inmate, he would look for multiple signs and symptoms of a mental health condition including how they present, whether they make eye contact, their body language, the way they interact, whether they are withdrawn, upset or aggressive. Benjamin Smith considered the process of information gathering to be crucial.
- 32 While he didn't specifically recall the interview, it would have been in person. He didn't recall how long he spent with PF. He said that often inmates are tired and the process is to assess them for immediate needs to ensure their safety for the night. Often the inmates are ready for sleep.
- 33 Benjamin Smith noted that PF did not show signs of being a risk of committing suicide or acts of self-harm and did not make any threats of suicide or self-harm. He denied receiving mental health treatment or taking prescribed medications.
- 34 PF told Benjamin Smith that he had attempted to hurt himself 'years ago'. He does not recall if PF gave him any further detail.

¹² Tab 156 P32

35 Benjamin Smith recorded that PF, 'guarantees [his] safety'. In his statement, Benjamin Smith said that PF had told him, 'that he would be ok' and that he could 'guarantee his safety in custody'.

Intake Screening Process

36 On 28 February 2023, Leesa Smith completed the ISQ¹³ on PF at MRRC. The purpose of this process is to identify risk factors and immediate needs. It is usually undertaken within 2 days of entry but sometimes up to 6 days. Leesa Smith had no specific recollection of her interview with PF. The interview takes place face to face. It can be calming for the inmate as it can be the first opportunity to call their family and tell them where they are.

37 Leesa Smith said it is not her practice to read through a case plan from a previous period in custody.

38 During that interview, PF is said to have provided an assurance that he could 'guarantee his own safety'. Leesa Smith accepted that assurance and did not assess PF as being at an immediate risk of self-harm or suicide. If she had considered him to be at immediate risk, she would have notified the JHNSW Nurse.

39 During her interview with PF, he told her that he was taking medications for his mental health. She did not inquire further as to the types of medications as she is not medically qualified and considered that to be an issue for JHNSW to identify. She considers her role to be one of flagging medications as an issue for JHNSW to then explore.

40 Leesa Smith said that she would have offered to refer him to a psychologist but he must have declined as she did not make the referral. She was asked whether PF's ability to guarantee his safety was premised on a positive court outcome and she indicated she is not able to predict what may happen in the future. The assessment of safety is undertaken based on the way in which the inmate is

¹³ Intake Screening Questionnaire.

presenting in the moment. If she does see an inmate after court she would assess them then in the same way she does after they take phone calls. She believes that inmates are spoken to after their court appearances to assess their safety.

- 41 Leesa Smith indicated that if she had considered PF to be at risk of self-harm she would have completed a Mandatory Notification, advised a senior correctives officer and put him on a RIT.

JHNSW Review

- 42 On 28 February 2023, Sarjeant conducted an RSA¹⁴ on PF at MRRC. The purpose of the RSA is to assess inmates for any primary health, mental health, drug and alcohol or population health issues that require immediate or ongoing treatment whilst in custody. Where health issues are identified, arrangements can be made for the inmate to be seen by the appropriate health specialist.

- 43 Sarjeant:

- (1) asserts she was told by PF that he was on Pristiq (an anti-depressant), quetiapine (an anti-psychotic) and mirtazapine (an anti-depressant)¹⁵
- (2) obtained from PF that his mental health history included anxiety, depression and PTSD and that he had received treatment for these conditions in the community
- (3) obtained PF's consent to obtain his external medical records
- (4) determined that PF was not at an immediate risk of self-harm.

- 44 Sarjeant completed a HPNF noting that PF had a previous period of incarceration and that he had mental health issues. She recommended he placed in a 'one out cell' until he could be reviewed for his mental health. This

¹⁴ Reception Screening Assessment.

¹⁵ See para 29.

was in response to PF asking to be housed alone because of his PTSD and previous trauma. Sargeant was concerned that a multiple cell placement could re-traumatise him.

- 45 On 2 March 2023, PF was seen by Ramesh Kharel from JHNSW's Ambulatory Mental Health Team as arranged by Sarjeant. During that assessment, PF noted that he had previously taken Seroquel 100 mg, Desvenlafaxine 50 mg and Avanza 45 mg. He had not been taking his medication for a month (including while in custody) and he would like to recommence¹⁶. PF reported 'low' mood but denied he was a 'safety risk.'

Classification process

- 46 On 10 March 2023, a CPT was convened by Cases to work out in which centre PF would be housed. While ordinarily the team would meet with the inmate, this did not occur because of COVID-19 protocols.
- 47 During the assessment, the CPT was required to consider whether PF was on any medications, whether he had any mental health conditions and whether this impacted on the classification. The assessment identified that PF had diagnoses for schizophrenia, depression and PTSD and described those conditions as 'serious mental health issues giving rise to a management concern'. The classification decision was reviewed by Shields.
- 48 The CPT assessment was undertaken in PF's absence, a consequence of Covid-19. PF's input was not sought, he was advised of the decision 2 days after it was made. This represented a loss of opportunity to assess PF for his future suicide risk.
- 49 The evidence in relation to whether or not PF's mental health history was taken into account in determining his placement was confusing. At question 2 of his Initial Classification Form, PF's mental health history was identified. Question 23 asked if that affected PF's placement and the answer was 'no.' However,

¹⁶ It was not established on the evidence that PF was in fact prescribed or taking those medications in the period immediately prior to his incarceration.

Cases asserted in his evidence, somewhat inconsistently, that the recommendation that PF be placed at SCCC had taken into account PF's mental health history. Importantly there was no evidence to the effect that SCCC was not an appropriate centre in light of PF's mental health history. What is also significant is the lost opportunity to glean insight into PF's then mental state in circumstances where the assessment was undertaken in PF's absence.

SCCC

PF's interactions with psychology services

50 On his transfer to SCCC on 13 June 2023, PF was added to a waitlist to see a psychologist, Medlock. Medlock saw PF on 22 June 2023 and during that meeting, PF:

- (1) disclosed that he had been a victim of an assault
- (2) declined to engage with psychology services explaining that he dealt with an external psychologist via AVL (Dr Hudd)
- (3) denied current thoughts of self-harm because he was confident that he would receive a positive outcome at court
- (4) disclosed not receiving his medication of Seroquel, Avanza and Pristiq since being in custody¹⁷.

51 On receiving a referral, Medlock's role was to provide psychological interventions and to liaise with JHNSW.

52 Medlock assessed PF as a 'psych 2' patient¹⁸. The distinction between levels 1 and 2 rests with the immediacy of stressors. Risks of self-harm and suicide are changeable particularly in the context of court dates, key anniversary dates and general decline in mental health. Medlock acknowledged that an assessment based on an inmate self-reporting did have limitations. He could access case

¹⁷ See para 29.

¹⁸ Being the second highest level of priority.

notes and PF's 'OIMS¹⁹' records. He did not recall a note on OIMS regarding PF's threat of self-harm out of concern he would not be granted bail. Medlock gave evidence that knowledge surrounding particular threats or attempts at self-harm would not have changed his assessment. These factors are historical, it was recognised that PF was at risk of self-harm and his risk would need to be assessed day by day. Medlock acknowledged that PF's reduced risk of self-harm was somewhat dependant on his optimism regarding a favourable court outcome. Medlock maintained PF at 'psych 2' status and kept him as a client despite PF indicating he would continue to see Hudd who was his psychologist in the community. Medlock did this given concerns around PF not receiving his medication, his previous suicide attempt and his potential suicide risk if he did not get a desired outcome at court.

- 53 PF told Medlock that he required a '1 out' cell placement as he was a victim of assault and that was how he was housed while in Junee Correctional Centre previously because of his mental health issues.
- 54 Medlock sent an email to JHNSW regarding PF's access to medication. Dr Elliott (JHNSW) reviewed PF on 28 June 2023 and PF told him that he was not seeking medication, just a 'one out' cell.
- 55 PF saw Medlock again on 31 July 2023. Medlock noticed significant improvements at that meeting. PF continued to express confidence as to his ability to 'beat the charges'. Medlock decided to keep PF at his existing level of priority. He arranged to see PF after his 'next Court date' being 13 September 2023. He was aware there was also to be a bail hearing in August.
- 56 On 2 August 2023, PF's Supreme Court bail application was not successful. He told his mum that he was not going to be there for his next court date in October.

¹⁹ Offender integrated management system.

57 On 11 September 2023, PF met with his lawyers and while we are not privy to that advice, PF reported that he was advised that he was facing ‘10 years imprisonment’.

58 Medlock was unable to meet with PF on 13 September 2023 due to a lockdown which had occurred on that day. Their appointment was re-arranged for 19 September 2023 – by which time PF was deceased.

59 On 14 September 2023, Medlock completed a file review of the information pertaining to PF on OIMS. He saw a case note dated 13 September 2023 which noted that PF had ‘no thoughts of self-harm and had no immediate concerns following his court appearance’ and that PF had not been sentenced, his next court date was 4 October 2023.

PF’s interactions with his case management officer

60 Wilson interviewed PF on 27 June 2023. At the time of that interview, she was aware of an alert made in respect of PF for self-harm. She saw the plans made by Medlock for follow up after PF’s next court date.

Dr Hudd

61 PF first saw Hudd on 18 August 2014. His treatment then focused on PF’s institutional sexual abuse, family neglect and being in foster care. PF recommenced counselling in August 2022. His treatment continued in custody via AVL. At this time, his treatment also related to his assault in custody and his fear of remaining in custody. He talked about suicide but didn’t have immediate plans. PF complained of not having access to medication²⁰.

62 In his oral evidence, Hudd described that suicide was always in the background with PF. Hudd didn’t consider there to be an acute risk as PF did not tell him he was planning to suicide. PF said in August 2023 that ‘he couldn’t stand it’ anymore. He said to Hudd that he was not thinking about killing himself, ‘he knows he will.’ When asked by Wilcox on cross examination, Hudd indicated

²⁰ Though notably when he saw Dr Elliot he was not concerned with re-commencing his medication.

he did not pass on concerns he had about PF to the goal because PF was not talking about 'doing it' – he was talking about suicidal ideations which were not uncommon. He also knew that PF was engaged with a psychologist within the correctional centre.

63 CSNSW confirmed in their submissions that external clinicians wanting to contact JHNSW about their patients can call a toll free Mental Health Helpline, the details of which are available on their website.

64 Hudd confirmed on cross examination by Harris that if he considered PF was at an imminent risk of suicide he would have called someone at the goal.

Investigations of PF's claims to have been assaulted in MRRC

65 PF reported being assaulted whilst in the MRRC on around 18 April 2023. The alleged assault was investigated by officers from Auburn Detectives. The investigations ceased on PF's death.

Events of 17 September 2023

66 On 17 September 2023, PF's mother attended the SCCC to visit PF. PF was crying during that visit. He told his mum that he, 'couldn't do the amount of time they were saying he was going to get'. PF's distress is visible on the available CCTV footage.

67 Consistent with the SCCC's routine, PF was locked in his cell at time between 3:00 and 3:30pm.

68 PF called his mum at around 5:30pm and they spoke briefly. PF was upset during that conversation.

69 CCTV footage indicates that PF did not leave his cell that evening. Nor did anyone enter his cell.

70 At 8.30am on 18 September 2023 PF was found in his cell in a semi squat hanging from the upper bunk frame. CPR was performed and a defibrillator was

administered. Paramedics arrived at 8.45am and PF was declared life extinct. He was aged 45 years.

Post-Mortem

71 An external post-mortem examination was conducted by Dr Bernard l'Ons on 21 September 2023. Noting the upward sloping ligature mark on the anterior and lateral aspects of the neck and the circumstances in which PF had been found, Dr l'Ons concluded that the cause of PF's death was 'in keeping with hanging.'

Issues

72 An issues list (extracted at paragraph [7]) was prepared prior to the inquest commencing to provide structure to the hearing. Some of the sub-issues are no longer of great relevance and other issues have emerged during the inquest. I have considered all of the submissions made by the parties and I am of the view that the following matters are the relevant issues that warrant discussion.

Findings as required by s 81 of the Act.

73 I am satisfied on the evidence adduced that PF died between 17 and 18 September 2023, at the South Coast Correctional Centre from hanging.

74 In relation to PF's manner of death, the evidence must be sufficiently clear and cogent to allow for a conclusion to be reached in relation to intention. The evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw v Briginshaw* 60 GLR 336).

75 I am satisfied to the *Briginshaw* standard on the evidence adduced that the manner of death was intentional self-harm.

76 I find on the evidence that during his time on remand PF was at a heightened risk of suicide particularly from 2 August 2023 following the court refusing to

grant him bail. This was further exacerbated from 11 September 2023 after PF received adverse or unexpected legal advice.

The management of PF's mental health in custody

77 The evidence establishes that at multiple stages during PF's custody, there was a requirement that PF be assessed in respect to his mental health and his risk of suicide. These assessments included:

- (1) during the reception process - conducted by Ben Smith
- (2) during the intake screening process - conducted by Leesa Smith
- (3) during the classification/placement stages - conducted by Cases and subsequently reviewed by Shields.²¹

78 The question arises as to whether these assessments could or should have been informed by greater detail about PF's specific risk factors including his previous threats and acts of self-harm. Such information could have been used to have identified a need for particular care to be accorded to PF after he had spoken to his lawyers and returned from his bail hearing.

79 The above assessments were conducted without the benefit of detailed knowledge of prior threats of self-harm and those conducting them were not psychologists or psychiatrists.

80 Whilst the reception and intake processes returned information about PF's mental health and potential risk of self-harm, I find that the information was not adequate and importantly, *not intended*, to allow his future risk to be identified in the circumstances that follow.

²¹ PF was also to be case managed by Wilson though her role was not primarily to identify issues related to welfare.

- (1) While Ben Smith and Leesa Smith knew of previous acts of self-harm neither were aware of the 2020 suicide attempt or the other two threats of self-harm. In particular:
 - (a) the May 2019 threat to 'hang himself' if bail refused; and
 - (b) the 20 July 2020 threat to 'slash up' occurred after an adverse outcome on sentence.
- (2) The reliance on the inmate to 'guarantee' their own safety may be misplaced if there is an intention to commit self-harm which is purposely not disclosed.
- (3) As the person conducting the intake screening, Leesa Smith did not consider it part of her role to ask more questions about a future risk of suicide. This may well in part reflect the fact that she (and Ben Smith) were not psychologically trained such that there were inherent limitations on their capacity to determine potential suicide risk beyond visible symptoms of anxiety, aggression or sadness.
- (4) The assessments were undertaken in a high pressure environment within a 30 minute or so time period.

81 That said, any systems and processes for identifying and responding to a risk of an inmate committing an act of self-harm can do no more than take steps that are 'reasonable' including by reference to their limited resources. It is to be remembered that the fact that PF had attempted self-harm in the past does not mean he had a mental health issue that needed to, or even could, be addressed²².

²² *Stuart v Kirkland-Veenstra* [2009] HCA 15 [44] per French CJ, at [91], [97]-[98] per Gummow, Hayne and Heydon JJ.

- 82 In PF's specific case, whilst the custodial records record that he had a history of mental illness²³ the evidence suggests that PF was not evidently acting in an irrational manner and was not acutely mentally unwell at the time of his death. This must have made it more difficult for those in CSNSW to observe and identify signs that he was at risk of committing an act of self-harm.
- 83 The reception, intake screening and classification/placement processes were each 'point in time' exercises. A person's risk of suicide evidently changes over time. As such, there were invariable limits in what could be achieved through those processes. Further, each of those processes was conducted by officers who had had no prior dealings with PF, which must inevitably have limited their ability to meaningfully assess any risk PF may then have presented of committing an act of self-harm.
- 84 Significantly, these point in time assessments were conducted, for the most part, by persons who were not qualified psychologists. This too must have hampered their ability to identify matters of risk for PF.
- 85 PF was engaged with CSNSW Psychologist, Medlock, though he also had limited knowledge of PF's risk in that his background information was obtained via the reception and intake screening processes and PF's self-reporting.
- 86 PF also continued to engage with his external psychologist, Hudd, with whom he had a long term therapeutic relationship. Hudd's evidence was telling. Having the benefit of longevity, and a psychologist, Hudd was best placed to identify PF's risk of self-harm. He did not consider the risk to be imminent and if he had, he said he would have made contact with CSNSW to advise them of the risk.
- 87 I accept the submissions by Counsel Assisting to the effect that PF's history of self-harm in the past does not mean he had a mental health issue that needed

²³ The intake screening form completed by Leesa Smith, for example, records that PF was suffering anxiety, bipolar, depression, PTSD.

to, or even could, be addressed²⁴. It may well be a rational decision for a person who is facing the prospect of an extended period in custody to seek to end his or her life.

- 88 If a person who attempts suicide cannot be presumed to be mentally unwell; it follows that he or she may be behaving rationally and in accordance with the sort of autonomy that the law, outside of a custodial context, permits an individual to take. A person who is not mentally ill and is behaving rationally in a desire to self-harm may show little or no observable signs of seeking to act on that intent.
- 89 Medlock appropriately maintained PF's classification as 'psych 2' reflecting that he was in need of psychological support at a high level. His external psychologist was also accessible to PF via AVL.
- 90 The timing of PF's death is relevant. He received his adverse bail decision on 2 August 2023 and his adverse legal advice on 11 September 2023 and died between 17 and 18 September 2023. If PF had been placed on a 'Mandatory Notification' following these events, as he had been on 10 June 2023 for example, it is unlikely that any practice of observing him in a camera cell would have continued for 6 days or thereabouts preventing his death. A risk of suicide is fluid, the time lapse is indicative that his risk of self-harm was not imminent on 2 August or 11 September.
- 91 Turning to PF's access to medications, Hudd gave evidence that PF complained of not having received his medications while in custody. The evidence did not support the contention that medications were withheld or otherwise not made available to PF. In particular:
- (1) the issue did not concern Hudd to the extent that he considered it appropriate to contact CSNSW and report it

²⁴ *Stuart v Kirkland-Veenstra* [2009] HCA 15 [44] per French CJ, at [91], [97]-[98] per Gummow, Hayne and Heydon JJ

- (2) Medlock's evidence confirmed that there was follow up with PF on the issue of medication
- (3) when the issue was followed up with Dr Elliot, PF advised he was not seeking medication, merely a 'one out' cell.

92 While ultimately the placement of PF in a 'one out' cell contributed to his capacity to harm himself unimpeded by a cell mate, the placement was not inappropriate given PF's background of PTSD and assault in custody.

Findings in relation to the management of PF's mental health in custody

93 My findings in relation to the management of PF's mental health in custody follow.

- (1) While more information could have been obtained from PF during his reception, intake and classification processes as to his history of self-harm, the processes that were undertaken were reasonable having regards to the limited resources and the fact that the officers involved were not psychologists. PF's history of mental illness and history of self-harm was recognised albeit with inadequate detail.
- (2) While the evidence as to whether or not PF's mental health history and history of self-harm was taken into account by the CPT when they determined that PF ought to be placed at the SCCC was inconsistent, there is no evidence indicating that the placement was inappropriate in light of his history of mental illness and self-harm or that it contributed to PF's death.
- (3) In custody PF was appropriately recognised as requiring a high level of psychological support (psych 2) and was engaged with both Medlock and Hudd.
- (4) Tragically, PF was to see Medlock on 13 September 2023, an appointment cancelled because of a Covid-19 lockdown. It is uncertain

whether this appointment may have acted as a 'circuit breaker' in respect of what we now know to be PF's deteriorating mental health.

- (5) The evidence does not suggest that additional interventions would have prevented PF's death or that his acute risk of suicide in the days prior to his death was identifiable. As such, save for the fact that PF had been refused bail and then met with his lawyers, there is no evidence of any trigger or 'red flag' which was missed in PF not being placed on an ISP or RIT.
- (6) Adequate inquiries were made with PF in relation to whether or not he required medication to assist with his mental health.
- (7) PF's placement in a 'one out' cell was not inappropriate given it was at his request and the reasons he made that request.

What was the role of JHNSW and did Justice Health carry out its role in a manner consistent with its own policies and procedures?

94 Justice Health was to respond to referrals made to it by CSNSW. Unfortunately, Hudd did not convey his concerns to CSNSW or contact Justice Health. The evidence adduced indicated that Dr Elliot did follow up with PF regarding his medication needs. There was no evidence adduced which indicated non-compliance by JHNSW with any of its policies and procedures.

Findings in relation to Justice Health

95 I find that there was no non-compliance by JHNSW with its own policies and procedures.

Recommendations

96 PF's death was tragic. His absence will be felt by his family for the rest of their lives. I seek in no way to detract from that in respect to my comments below.

- 97 As outlined above, more information could have been obtained at the reception and intake phase in relation to PF's previous history of actual and threatened self-harm, however, I considered the steps taken were adequate when considered in the context of limited resourcing.
- 98 PF's death also needs to be considered in the context of the pandemic. Two significant issues arose as a consequence of the pandemic:
- (1) that the CPT did not undertake an in person assessment of PF; and
 - (2) that PF's appointment with Medlock on 13 September 2023 was cancelled because of a lockdown.
- 99 Given the absence of evidence of any systemic failures on the part of CSNSW and JHNSW I do not consider it appropriate to make any recommendations.

Concluding remarks

- 100 I will close by conveying to the family my sympathy for the loss of PF.
- 101 I thank the Assisting team for their outstanding support in the conduct of this inquest.
- 102 I thank the officer in charge, DSC Emily Steele for her work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

- 103 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is PF

Place of death

South Coast Correctional Centre

Date of death

Between 17 and 18 September 2023

Cause of death

Hanging

Manner of death

Intentional self-harm while in lawful custody

I close this inquest.



Magistrate R Hosking

Deputy State Coroner

Lidcombe
