New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Roland Ashbolt
Hearing dates:	12 June 2025
Date of Findings:	12 June 2025
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, clozapine toxicity, clozapine administration protocol, diversion and stockpiling of medication
File number:	2022/189166
Representation:	Mr D Welsh, Coronial Advocate Assisting the Coroner Ms K Guilford for Justice Health & Forensic Mental Health Network Ms A Poulios for the Commissioner of Corrective Services New South Wales
Findings:	Roland Ashbolt died on 28 June 2022 at the Mental Health Unit, Long Bay Correctional Centre, Malabar NSW 2036. The cause of Mr Ashbolt's death was clozapine toxicity. Mr Ashbolt died from misadventure due to unintentional drug overdose whilst on remand in lawful custody.
Non-publication orders:	See Annexure A

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1. Introduction

1.1 Roland Ashbolt was a 39-year-old man who was being held on remand in lawful custody at Long Bay Correctional Centre. On the afternoon of 27 June 2022, Mr Ashbolt was returned to his cell. Later that evening at around 7:00pm, Mr Ashbolt was checked on and provided with his prescribed medication. Nothing amiss was noted at the time.

1.2 At around 7:43am on 28 June 2022, correctional officers conducted a routine morning round and observed Mr Ashbolt in his cell lying face down on his bed, unresponsive and showing no signs of life. Emergency medical assistance was sought and resuscitation efforts were initiated. However, Mr Ashbolt could not be revived and was later pronounced life extinct at 8:17am.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**). It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Ashbolt was not appropriately cared for and treated whilst in custody.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Ashbolt's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Ashbolt was born in Armidale to Shelley and Anthony Ashbolt. He had three siblings. When Mr Ashbolt was seven or eight years old his family moved to Wollongong. Mr Ashbolt's mother describes him as being very bright but unable to apply himself to his studies.

3.3 Unfortunately, little else is known about Mr Ashbolt's personal background. However, there is no doubt that Mr Ashbolt's niece and loved ones still feel his loss most deeply.

4. Mr Ashbolt's medical history

4.1 In around 2007, Mr Ashbolt received a custodial sentence after being charged with a property offence. Following his release, family members observed that Mr Ashbolt's mental health had declined. He exhibited aggressive and paranoid behaviour and began to smoke cannabis and increase his alcohol consumption. Mr Ashbolt later attended a rehabilitation facility in Wollongong where he underwent a psychological evaluation. Following this assessment, Mr Ashbolt was diagnosed with schizophrenia.

4.2 In 2008 or 2009, Mr Ashbolt was prescribed clozapine, which is a medication reserved for treatment-resistant forms of schizophrenia when response to standard medication has been inadequate. According to his mother, Mr Ashbolt responded well to the clozapine and it suppressed Mr Ashbolt's paranoia. Mr Ashbolt later found work with a private bush regeneration company. He also ceased his alcohol consumption, began to exercise and improve his quality of life.

4.3 In 2014, Mr Ashbolt ceased taking his clozapine without informing his family as he believed that it was making it difficult for him to function at work. Mr Ashbolt subsequently began to exhibit paranoid behaviour again and thoughts of self-harm. This resulted in Mr Ashbolt subsequently attempting self-harm by way of clozapine and alcohol overdose.

4.4 In 2016, Mr Ashbolt began using methamphetamine regularly. He also became estranged from his siblings and other family members.

4.5 By 2018, Mr Ashbolt had increased his alcohol consumption and continue to use methamphetamine regularly. He was also showing extreme paranoid behaviour.

5. Mr Ashbolt's custodial history

5.1 On 23 March 2021, Mr Ashbolt was arrested and charged with a number of alleged sexual assault offences. He was refused bail and was initially remanded at Parklea Correctional Centre. In April 2021, Mr Ashbolt was transferred to the Metropolitan Remand and Reception Centre (**MRRC**) whilst

awaiting the outcome of his criminal proceedings. During this period, Mr Ashbolt exhibited self-harming behaviour and described feelings of hopelessness.

5.2 In December 2021, Mr Ashbolt was referred from the Mental Health Screening unit at the MRRC to the Long Bay Hospital Mental Health Unit (**MHU**) as a scheduled patient under the *Mental Health and Cognitive Impairment Provisions Act 2020*. It was reported that Mr Ashbolt was severely mentally unwell with both psychotic symptoms and depressed mood, and that his symptoms had not responded to treatment with several antipsychotic and antidepressant medications. It was also noted that Mr Ashbolt had made four self-harm attempts during his time in custody: two incidents when he cut himself in the neck, one incident when he swallowed two AA batteries, and one incident when he overdosed on lithium. On three of these occasions, Mr Ashbolt was transferred to Westmead Hospital and later cleared to return to custody.

5.3 On 16 December 2021, Mr Ashbolt was first assessed by his treating psychiatrist, Dr Matthew Hearps, Deputy Clinical Director – Custodial Mental Health (Long Bay Hospital), Justice Health. Mr Ashbolt demonstrated persecutory delusional beliefs and described depressed mood and suicidal ideation. He was assessed as unlikely to improve in his mood unless his psychotic symptoms were better controlled.

5.4 A treatment plan was formulated to commence a clozapine workup. Mr Ashbolt described a previous positive response to clozapine when treated in the community and agreed to recommencing it. Dr Hearps noted that the decision to treat Mr Ashbolt with clozapine was made based on his failure to respond to treatment with standard antipsychotic medication.

5.5 Following the workup period, Mr Ashbolt commenced clozapine on 19 January 2022. It was administered orally, meaning nursing staff had to supervise Mr Ashbolt taking the clozapine in tablet form.

5.6 Mr Ashbolt's clozapine dose was gradually increased. By 9 February 2022, he was being treated with 300mg daily.

5.7 By early March 2022, Mr Ashbolt showed a gradual but definite response to treatment. It was noted that his mood had improved and deliberate self-harm ideation had remitted. On 8 March 2022, Mr Ashbolt was moved from a camera cell to a non-camera cell and checked on at hourly intervals by nursing staff.

5.8 On 4 April 2022, it was noted that Mr Ashbolt's clozapine blood level was 0.289 mg/L, with the therapeutic range being between 0.35 to 0.6 mg/L. on 22 April 2022, Mr Ashbolt's clozapine dose was increased to 350 mg.

5.9 On 16 May 2022, Dr Hearps reviewed Mr Ashbolt and found that he was exhibiting delusional beliefs. Mr Ashbolt's dose of clozapine was increased to 400 mg on the same day.

5.10 On 24 May 2022, Dr Hearps reviewed Mr Ashbolt again and found no psychotic symptoms evident at interview. No further changes were made to Mr Ashbolt's clozapine dose after this time and he remained on 400 mg daily.

5.11 On 31 May 2022, Dr Hearps reviewed Mr Ashbolt again and discussed a transfer from Long Bay Hospital to 13 Wing, a mental health stepdown area in Long Bay Correctional Centre. Mr Ashbolt was agreeable to this course and reported that he had no thoughts of self-harm. At the time, Mr Ashbolt was assessed as having had a good response to clozapine, his psychotic symptoms of schizophrenia were well-controlled, and his mood was good. He remained on clozapine and the same antidepressant medications, venlafaxine and mirtazapine.

5.12 Whilst awaiting transfer, Mr Ashbolt continued to be reviewed by Dr Hearps and the psychiatric registrars, with his clozapine levels monitored. On 4 June 2020, Mr Ashbolt's clozapine level was noted to be slightly high at 0.693 mg/L. However, on 27 June 2022, it was noted that Mr Ashbolt's clozapine level had decreased to 0.568 mg/L.

5.13 Mr Ashbolt was last reviewed by Dr Hearps on 20 June 2022 when it was noted that Mr Ashbolt reported that he was doing well, was happy with clozapine and was still agreeable to being transferred to 13 Wing. The following day, Dr Hearps conducted a case review in which it was noted that Mr Ashbolt's mental state remained stable and that he was awaiting transfer to 13 Wing.

6. The events of 27 and 28 June 2022

6.1 On 27 June 2022, Mr Ashbolt interacted with other inmates in common areas and watched TV during the day. Nothing amiss was noted.

6.2 At around 2:23pm, Mr Ashbolt and the other inmates returned to their cells in accordance with usual procedures. At around 7:00pm, Justice Health staff provided Mr Ashbolt with his medications and checked his vital signs which were within normal ranges.

6.3 At around 6:00am on 28 June 2022, a head check was conducted by CSNSW staff and Mr Ashbolt was noted to still be in his cell. Later that morning at 7:43am, CSNSW staff began serving breakfast to the inmates in Mr Ashbolt's ward. Upon approaching Mr Ashbolt's cell, staff members observed Mr Ashbolt lying face down on his bed, unresponsive and showed no signs of life. Justice Health staff were alerted and emergency medical services were contacted. Resuscitation efforts were commenced and continued by NSW Ambulance paramedics who attended the scene a short time later. However, Mr Ashbolt could not be revived and was later pronounced life extinct at the scene.

7. What was the cause of Mr Ashbolt's death?

7.1 Mr Ashbolt was subsequently taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Jennifer Pokorny, forensic pathologist, on 6 July 2022. This identified the following relevant findings:

(a) an enlarged heart although the coronary arteries were patent and there was no evidence of acute or chronic ischaemic injury;

(b) congested lungs;

(c) toxicological analysis detected clozapine at 4.6 mg/L, with venlafaxine and its metabolite detected at supratherapeutic levels, and mirtazapine detected at a therapeutic level; and

(d) a single focus of myocarditis in the heart which Dr Pokorny noted is a finding that may be seen as an adverse or toxic effect of clozapine.

7.2 Dr Pokorny noted that although the level of clozapine detected is within the reported lethal range, clozapine is known to rise significantly with increased post-mortem interval and the autopsy in this case was performed eight days after death. However, Dr Pokorny also noted that the detected level in Mr Ashbolt's case is almost six times higher than the upper end of the range usually seen with therapeutic use and almost three times higher than the lower end of the reported lethal range. Dr Pokorny then went on to express this view:

> It would appear extremely unlikely that a level similar to this around the time of death could have increased to that detected in the blood sample collected at autopsy as a result of artefactual postmortem increase alone; the post-mortem result is much more suggestive of a true potentially lethal level due to medication overdose.

7.3 In the autopsy report dated 27 September 2022, Dr Pokorny opined that the cause of Mr Ashbolt's death was clozapine toxicity.

8. Focus of the coronial investigation

8.1 The coronial investigation sought to answer four questions:

(a) Was the level of clozapine detected post-mortem artefactual?

(b) If the clozapine level was not artefactual, was the prescription of clozapine to Mr Ashbolt managed appropriately?

(c) Were appropriate measures in place to prevent the potential stockpiling or hoarding of clozapine by Mr Ashbolt?

(d) What was the manner of Mr Ashbolt's death

8.2 Each of these questions is considered individually in more detail below.

9. Was the post-mortem clozapine level artefactual?

9.1 Professor Alison Jones, a specialist general physician and clinical toxicologist, was instructed to provide an opinion regarding this question.

9.2 Professor Jones noted that Mr Ashbolt's antemortem clozapine concentration on 27 June 2022 was 0.568 mg/L which represented a therapeutic level of the drug. Professor Jones explained that when undertaking therapeutic drug monitoring for clozapine the aim is to keep a patient's clozapine concentration between 0.35 to 0.6 mg/L, the same range expressed by Dr Hearps above.

9.3 As to the level of clozapine detected from Mr Ashbolt's post-mortem blood sample, Professor Jones expressed this view:

> The reported clozapine post-mortem blood concentration of 4.6 mg/L in Mr Ashbolt represents clozapine well within the toxic and fatal ranges of clozapine. Such a level would not result from therapeutic use of the drug, using therapeutic doses. To achieve this level one or more overdose of clozapine would need to have been taken between the timing of the therapeutic drug monitoring blood result on the 27th June 2022 and the post-mortem blood sample taken 8 days after Mr Ashbolt's death on the 28th July 2022.

9.4 Professor Jones went on to explain that post-mortem redistribution occurs when drugs move from organs of high drug concentrations down a concentration gradient into the blood. As Mr Ashbolt's post-mortem examination was performed eight days after his death, Professor Jones explained that post-mortem redistribution could have occurred, meaning that the toxicology results regarding clozapine might be higher than the actual concentrations in Mr Ashbolt's blood around the time of his death. Professor Jones explained that when corrected for likely post-mortem redistribution effect, the actual blood concentration of clozapine at around the time of death was 3.26 mg/L. This still represents a level within the reported toxic and fatal ranges.

9.5 After excluding the possibility of genetic variation and a laboratory error of some kind, Professor Jones opined:

> [T]he most rational interpretation of Mr Ashbolt's post-mortem blood concentration of 4.6 mg/L is that it was truly elevated at a toxic or fatal blood concentration and compatible with one or more overdoses of the drug.

9.6 Professor Jones also opined that the clozapine detected at post-mortem is likely to have caused Mr Ashbolt's death by direct toxicity. It is noted that clozapine can cause death by central nervous system and/or respiratory depression and fatal cardiac arrhythmia by prolongation of the QTc interval.

9.7 **Conclusions:** The expert evidence establishes that the clozapine detected in Mr Ashbolt's post-mortem blood sample was not artefactual and represented a true supratherapeutic level. Even allowing for post-mortem redistribution, the actual blood concentration of clozapine at around the time of Mr Ashbolt's death was still within the reported toxic and lethal ranges.

9.8 The last measurement of Mr Ashbolt's clozapine level on the day before he was found unresponsive was 0.568 mg/L which is within the reported therapeutic range. The finding of a significantly elevated level of clozapine post-mortem was most likely the result of the ingestion by Mr Ashbolt of one or more overdoses of clozapine.

9.9 The toxic effects of clozapine overdose likely resulted in central nervous system and/or respiratory depression and/or a fatal cardiac arrhythmia resulting in Mr Ashbolt's death.

10. Was administration of clozapine to Mr Ashbolt managed appropriately?

10.1 Given that Mr Ashbolt had been prescribed clozapine in custody and the evidence demonstrated that the cause of his death likely resulted in one or more overdoses of this medication, Professor Matthew Large, a Senior Staff Specialist and Medical Superintendent of Mental Health Services at the Prince of Wales Hospital, was instructed to provide an opinion regarding this question.

10.2 Professor Large noted that Mr Ashbolt had a combination of symptoms of schizophrenia and severe depressive symptoms, that his psychosis had a limited response to long-acting antipsychotic injections, and that he had a history of previous response to clozapine. For these reasons, Professor Large considered that the prescription of clozapine to Mr Ashbolt was clinically indicated and "*the only realistic therapeutic option for the treating team and Mr Ashbolt*".

10.3 Professor Large also noted that:

(a) Mr Ashbolt's history of overdosing "*should not have prevented the use of clozapine*" whilst Mr Ashbolt was in custody in 2022; and

(b) the clinical notes suggest that clozapine was effective and not causing undue side effects or toxicity in the period between 18 January 2022 and 28 June 2022 when Mr Ashbolt had some ongoing psychotic symptoms and required clozapine.

10.4 As to the question of whether the administration protocol of clozapine to Mr Ashbolt, and clinical observations of him, were appropriate, Professor Large expressed this opinion:

> Mr Ashbolt was on a stable and moderate dose of clozapine at the time of his death. There were no solid reasons for post-administration monitoring of vital signs and level of consciousness on physiological grounds, and such monitoring would not be used to prevent overdose in practice. A nurse administering Mr Ashbolt's medication and examining his oral cavity after swallowing some water is a routine and acceptable way of monitoring medication compliance, including compliance with clozapine.
>
> Even considering his previous overdoses, it would have been overcautious to have prescribed clozapine in its liquid form to Mr Ashbolt to prevent an overdose. Liquid clozapine significantly increases the risk of dosing errors because the volume must be measured. It would have been reasonable to prescribe liquid clozapine to Mr Ashbolt when he was actively expressing suicide ideas and had current self-harm but it would not have been reasonable in the longer term when he appeared to have an improved mood, had less suicidal ideation, and had therapeutic clozapine levels.

10.5 Overall, Professor Large considered that the clozapine administration protocol for Mr Ashbolt was appropriate. Whilst Professor Large observed that, in retrospect, room searches, greater scrutiny of the oral cavity after medication administration, and the use of liquid clozapine might have detected or prevented clozapine hoarding (if this had in fact occurred) and reduced the possibility of overdose, he opined that none of these measures were strongly indicated.

10.6 **Conclusions:** Notwithstanding an incident of clozapine overdose whilst Mr Ashbolt was in the community, the prescription of clozapine to Mr Ashbolt whilst in custody was appropriate. This is because other treatment options, including other medications, had previously been used without success. In contrast, Mr Ashbolt exhibited a positive response to clozapine and showed no side-effects between January 22 and June 2022.

10.7 The administration protocol of clozapine to Mr Ashbolt was also appropriate. He was supervised by nursing staff whilst the medication was administered and his oral cavity was checked following administration. The expert evidence establishes in retrospect that whilst additional measures could have been taken to mitigate against the possibility of clozapine diversion and stockpiling, none of these measures were strongly indicated at the time that Mr Ashbolt was administered clozapine.

11. Were appropriate measures in place to prevent the potential stockpiling or hoarding of clozapine?

11.1 The evidence establishes that the most likely explanation for the significantly elevated clozapine level seen post-mortem was due to one or more overdoses. Given that Mr Ashbolt was administered therapeutic doses of clozapine it appears that these overdoses were most likely achieved through the diversion and stockpiling/hoarding of clozapine. It should be made clear that there is no definite evidence that this occurred.

11.2 Notwithstanding, evidence was gathered to consider the possibility of medication diversion and stockpiling, and whether appropriate measures existed at the time, and currently, to mitigate against the possibility of such practices. Assistant Superintendent Timothy Peek, the Acting (as at August 2023) Manager of Security, CSNSW Security and Custody, stated that Mr Ashbolt's cell was searched 25 times between 8 March 2022 (the date he entered the cell) and 28 June 2022 with nil contraband items found. All of these searches were randomly generated except for a targeted search on 26 June 2022 for all inmates who received visits. However, as Mr Ashbolt did not receive a visit on this date, his cell was not searched.

11.3 Senior Assistant Superintendent Peek also explained that in the period between January 2022 and June 2022:

(a) If CSNSW received information from Justice Health that an inmate had a history of hoarding medication, CSNSW "*may alter how an inmate is managed as advised by Justice Health*". For example, medication rounds may be supervised.

(b) If CSNSW received information from Justice Health that an inmate was suspected of hoarding medication, the following steps would be taken in accordance with the *Custodial Operations Policy and Procedure* (**COPP**).

11.4 The COPP provides for:

(a) cell searches to be conducted regularly to identify any instances of medication diversion and stockpiling;

(b) additional cell searches may be carried out at any time if there is intelligence warranting such searches;

(c) if stockpiled medication is found it is confiscated and forwarded to the Justice Health Nurse Unit Manager to determine if the medication was authorised; and

(d) if an inmate is found to be stockpiling medication, a misconduct report may be prepared and the inmate may then be supervised while taking medication.

11.5 Dr Hearps stated that he could not recall if he was aware whether Mr Ashbolt had a history of stockpiling medication. However, Dr Hearps explained that the following elements of Mr Ashbolt's management in the MHU at Long Bay Hospital "*would have the effect of reducing the likelihood of stockpiling medications*":

(a) clozapine is a medication that must be supervised;

(b) the administration of all medication in the Long Bay Hospital MHU was and is supervised by nursing staff;

(c) Mr Ashbolt was subject to continuous camera monitoring during the period from 15 December 2021 to 8 March 2022; and

(d) following his transfer on 8 March 2022, Mr Ashbolt was subject to hourly nursing checks to monitor his safety and welfare.

11.6 Dr Hearps also stated that if a patient was suspected of stockpiling medication, Justice Health staff could inform CSNSW about this.

11.7 **Conclusions:** The evidence establishes that appropriate measures were put in place by both CSNSW and Justice Health to mitigate against the possibility of medication diversion and stockpiling. Regular cell searches, continuous camera monitoring and hourly nursing checks were all utilised in the case of Mr Ashbolt. There is no evidence to suggest that anything more could have reasonably been done to prevent any potential clozapine diversion and stockpiling by Mr Ashbolt.

12. What was the manner of Mr Ashbolt's death?

12.1 It is evident from Mr Ashbolt's medical history described above that he had previously voiced suicidal ideation and attempted self-harm, including by clozapine overdose. These matters immediately raise the question whether Mr Ashbolt's death was intentionally self-inflicted, again by way of clozapine overdose.

12.2 Set against this background, other evidence of Mr Ashbolt's response to the prescription of clozapine from January 2022 establishes that his response was good and that the clozapine was having a therapeutic effect. Indeed, Dr Hurst noted that Mr Ashbolt's deliberate self-harm ideation had remitted and that at the time of his death his condition had improved to the point where he was awaiting transfer to a mental health stepdown area.

12.3 **Conclusions:** There is no reliable evidence that any clozapine ingested by Mr Ashbolt shortly before his death was done with the intention to end his life. Although Mr Ashbolt had a history of suicidal ideation and self-harm attempts, the evidence of his medical history between January 2022 and June 2022 demonstrates an improvement of his mental health and no self-harm attempts or expressions of suicidal ideation approximate to the time of his death. Therefore, the manner of Mr Ashbolt's death is best described as misadventure due to unintentional drug overdose.

13. Findings

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Durand Welsh, Coronial Advocate Assisting the Coroner, for the assistance provided throughout the coronial investigation and the sensitivity shown to Mr Ashbolt's relatives.

13.2 I also thank Plain Clothes Constable Rebecca Zambesi for her role in the police investigation and for compiling the initial brief of evidence.

13.3 The findings I make under section 81(1) of the Act are:

Identity
The person who died was Roland Ashbolt.

Date of death
Mr Ashbolt died on 28 June 2022.

Place of death
Mr Ashbolt died at the Mental Health Unit, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death
The cause of Mr Ashbolt's death was clozapine toxicity.

Manner of death
Mr Ashbolt died from misadventure due to unintentional drug overdose whilst on remand in lawful custody.

13.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Ashbolt's family and loved ones for their loss.

13.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
12 June 2025

Coroners Court of New South Wales

Inquest into the death of Roland Ashbolt

File Number: 2022/189166

Annexure A

Non-Publication Orders

1. Pursuant to section 74(1)(b) of the Coroners Act 2009 (the Act), the following material contained is not to be published:

    a. The names, telephone numbers, residential addresses and any other identifying information of any member of Roland Ashbolt's family, friends and/or visitors (other than legal representatives or visitors acting in a professional capacity);

    b. The direct contact details including telephone numbers, email addresses, OIMS usernames and employee identification numbers of CSNSW officers and employees that are not publicly available;

    c. The names, Master Index Numbers, and other identifying information of inmates other than Mr Ashbolt;

    d. The name and identifying information of the alleged victim of Mr Ashbolt;

    e. CCTV and body-worn camera video footage; stills of any video footage and photographs of Long Bay Hospital Correctional Centre, CCTV monitoring areas, and of the deceased, Mr Ashbolt, following his death;

    f. The Risk Intervention Team management and observation plan that details information regarding restraints or other security measures required in regard to hospital escorts;

    g. Portions of the investigation report that reveal which cells do or do not contain CCTV.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
12 June 2025
Coroners Court of New South Wales