



New South Wales

**CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of Alexander Gavranic

Hearing date(s): 21 to 23 September 2026

Date of Findings: 14 October 2026

Place of Findings: Coroner's Court of New South Wales, Lidcombe

Findings of: Judge Derek Lee, Deputy State Coroner

Catchwords: CORONIAL LAW – death in custody, manner of death, intentionally self-inflicted death, Junee Correctional Centre, access by inmates to mental healthcare services, pathways for referrals or requests, inmate demand for mental healthcare, availability of mental healthcare staff, funding and resourcing of mental healthcare services, cable ties

File number: 2023/00039250

Representation: Ms A Storm, Coronial Advocate Assisting the Coroner

Ms T Berberian for GEO Group Australia Pty Ltd, instructed by Sparke Helmore

Ms J De Castro Lopo for the Commissioner of Corrective Services New South Wales

Mr M Hutchings for the Family of Alexander Gavranic, instructed by AJHLAW

Findings pursuant to section 81(1) *Coroners Act 2009*.

Alexander Gavranic died on 5 February 2023 at Junee Correctional Centre, Junee NSW 2663.

The cause of Alexander's death was asphyxiation due to cable tie compression of neck.

Alexander died whilst being held in lawful custody at Junee Correctional Centre as a result of actions taken by him with the intention of ending his life. He died in circumstances where he had been on a waitlist for at least 305 days to access mental healthcare services with no such services provided. However, it is not possible to determine whether access to such services prior to 5 February 2023 would have materially altered the eventual outcome.

Recommendations pursuant to section 82(1) *Coroners Act 2009*

To the Commissioner of Corrective Services New South Wales:

1. I recommend that guidance or instructions be provided to correctional officers regarding the need to thoroughly document any request made directly by an inmate to a correctional officer for assistance with accessing mental healthcare services. This is so that if the request is not actioned in a timely manner, appropriate follow-up and escalation of the request to a senior correctional officer can occur.

To the Governor, Junee Correctional Centre:

2. I recommend that the findings of this inquest be used to advance the position before any future funding or budgetary allocation process that the staffing profile of mental healthcare services at Junee Correctional Centre be increased so that the significant demands of the inmate population for such services are adequately met.

Table of Contents

1. Introduction	1
2. Why was an inquest held?.....	1
3. Alex's life.....	2
4. Alex's medical and custodial history	3
Diary entries	3
5. The events of 4 February 2023.....	4
6. Post-mortem examination	5
7. Outcome of the NSWPF investigation	5
8. What issues did the inquest examine?	6
9. Reception screening assessment	6
10. Mental health assessment of inmates between June 2021 and February 2023	7
Self-referral	7
Sick parade.....	9
Email referral from a correctional officer.....	9
Phone referral from a correctional officer	11
Offender Integrated Management System.....	13
Requests initiated by family members.....	13
11. Mental health assessment of inmates currently.....	14
12. Availability of resources.....	16
13. Findings	19
Identity	19
Date of death.....	19
Place of death.....	19
Cause of death.....	19
Manner of death	19

1. Introduction

- 1.1 Alexander (who was known to his family as Alex) Gavranic was a 40-year-old man who was being held in lawful custody at Junee Correctional Centre (**Junee**) on remand whilst awaiting trial in relation to criminal proceedings. Whilst in custody, Alex made several efforts requesting to see a mental health nurse, including completing a request form on 30 January 2023.
- 1.2 On the afternoon of 4 February 2023, Alex was locked in his cell in accordance with routine nightly procedures. Throughout the course of the evening and into the early hours of the morning, correctional officers performed routine checks at Alex's cell and the other cells in his accommodation unit.
- 1.3 At around 4:45am on 5 February 2023, another check was performed and it was noticed that Alex could not be seen within his cell. The cell was immediately opened and Alex was found sitting on the floor with cable ties fastened around his neck. Alex was unresponsive and showed no signs of life.
- 1.4 Resuscitation efforts were initiated and an emergency medical response was activated. However, despite continued resuscitation efforts, Alex could not be revived and was tragically pronounced life extinct at 5:10am.

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 be answered 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 correctional and healthcare staff.
- 2.4 In Alex's case, the circumstances of his death raised several questions regarding his requests to see a mental health nurse, his ability to access healthcare services, and the general pathways by which such access can be facilitated for inmates.
- 2.5 It should be noted that at the time of Alex's death, the GEO Group Australia Pty Ltd (**GEO**) had been retained by the Commissioner of Corrective Services New South Wales (**CSNSW**) to privately

operate and manage Junee under the direction and control of the Minister for Corrections and the Commissioner of CSNSW. Health services for inmates at Junee were provided by GEO Healthcare. On 1 February 2025, responsibility for the operation and management of Junee reverted to CSNSW with healthcare services provided by Justice Health & Forensic Mental Health Network (**Justice Health**).

- 2.6 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 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. Alex'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 Alex's life in a brief, but hopefully meaningful, way.
- 3.2 Alex was born in Auburn in 1982 to his parents, Patricia and Zoran Gavranic. He was the oldest of four children with two brothers and a sister. When Alex was 18 months old, the family moved to Victoria. Alex attended primary school in Chilton and then high school in Rutherglen and Wodonga up to Year 10.
- 3.3 After leaving school, Alex obtained work as a concreter and was required to travel often for his work. Alex later moved to Canberra for several years before returning to Wodonga. At some stage Alex formed a relationship and in November 2004, his daughter was born.
- 3.4 In 2005, Alex moved to Melbourne and remained there until 2007 when he moved to South Australia. Whilst in Melbourne, Alex formed a new relationship described as being on and off over several years. In late 2019, Alex moved back to Chiltern temporarily and lived with his parents before moving to Albury.
- 3.5 Alex's family describe him as a fun, personable and kind-hearted man with a larger-than-life personality. Alex was known to have a laugh that could captivate an entire room and to be devoted to his family. He was a much loved father, son, brother and uncle.
- 3.6 Alex was someone who cared deeply about his family and those closest to him. Alex would selflessly do anything for them, no matter how big or small.

- 3.7 Alex's untimely passing has had a profound effect on his family. He is particularly missed at birthdays, celebrations, family gatherings and other life milestones. However, his absence from the lives of those closest to him continues to be deeply felt every day. Alex remains a greatly missed and loved member of his family who will always remain a part of their lives.

4. Alex's medical and custodial history

- 4.1 In around 1996, Alex first came into contact with the criminal justice system. Over the subsequent years, Alex was convicted of a variety of offences in Victoria and the Australian Capital Territory ranging from driving offences, dishonesty offences and illicit drug-related offences. Some of these convictions resulted in periods of imprisonment.
- 4.2 In around 2003, Alex was diagnosed with attention deficit hyperactivity disorder and prescribed dexamphetamine. However, Alex later reportedly ceased taking his medication due to adverse side effects. According to family members, Alex began "harder" drugs around this time in order to self-medicate.
- 4.3 At some point, Patricia took Alex to the emergency department at Wodonga Base Hospital after Alex was noticed to be exhibiting unusual and concerning behaviour. After being admitted, Alex was transferred to a different facility for inpatient psychiatric care.
- 4.4 Between 2007 and 2019, Alex was incarcerated for periods of time in South Australia. In December 2019, he was last released from custody in South Australia. During his periods in custody, Alex received antidepressant medication. Upon his release from custody, Alex reportedly often recommence using illicit substances.
- 4.5 On 18 June 2021, Alex was arrested in Victoria pursuant to warrants that had been obtained by the New South Wales Police Force (**NSWPF**) in relation to offences which were alleged to have occurred in December 2020. He was extradited to New South Wales and appeared before Albury Local Court where he was refused bail and remanded into custody.
- 4.6 On 21 June 2021, Alex was received into custody at Junee. This was his first period of custody in New South Wales. Alex's criminal proceedings were first listed for trial in October 2022. However, the trial did not proceed and was relisted in February 2023.
- 4.7 In January 2022, Alex was temporarily transferred to the Metropolitan Remand and Reception Centre (**MRRC**) after testing positive for COVID-19 infection. On 2 February 2022, Alex was transferred back to Junee.
- 4.8 In January 2023, Alex again tested positive for COVID-19 infection and was required to isolate in his cell.

Diary entries

- 4.9 During his time at Junee, Alex kept diaries in which he recorded various thoughts and events during 2022 and 2023. A summary of relevant entries written by Alex is set out below:

- (a) 7 July 2022: “*See la Shai about mental health and she said no mental health nurse in jail. Said I was unwell*”;
- (b) 1 December 2022: “*Asked Enq for SAPO (Services and Program Officer)*”;
- (c) 15 December 2022: “*Asked Enq to see SAPO*”;
- (d) 28 December 2022: “*Enq, Put in mental health request gave it to harry potter and asked to see sapo*”;
- (e) 8 January 2023: “*Put in mental health form in [sic] gave it to African screw*”;
- (f) 13 January 2023: “*seen ms conners at Enq and asked her to chase up mental health*”;
- (g) 20 January 2023: “*Covid test positive, also spoke to mr baird and said I asked ms conners about mental health at enquiries and asked him to chase it up*”;
- (h) 30 January 2023: “*seen Mr Willis about mental health and also ENQ*”;
- (i) 31 January 2023: “*Ms Reed said Mum rang the jail about my mental health and she said was told it was the first time I have heard about it. Ms Reed said she would get onto it in the morning and would get back to me tomorrow*”;
- (j) 1 February 2023: “*Ms Read said she rang mental health and was waiting for a answer*”.

5. The events of 4 February 2023

- 5.1 On 4 February 2023, Alex followed his usual daily routine, collecting his meals, interacting with other inmates and using the shower facilities. At around 12:30pm, Alex had a video call with his mother. According to Patricia, during this call she asked Alex if he had seen a doctor and he indicated that he had not. Alex was also reportedly upset during the call because a usual video call with his mother had not taken place a day earlier.
- 5.2 At around 5:10pm, Alex was secured in his cell for the evening lock-in. CCTV footage shows that correctional officers performed checks at Alex’s cell at around 9:30pm, 11:45pm, 12:00am and 12:30am as part of usual overnight security procedures.
- 5.3 At around 4:45am on 5 February 2023, a correctional officer looked through the inspection hatch of Alex’s cell but was unable to see Alex. The cell door was opened and Alex was found sitting on the floor with his back against the bed and with cable ties fastened around his neck. Alex was unresponsive and showed no signs of life.
- 5.4 Correctional officers cut the cable ties and commenced resuscitation efforts. Emergency services were contacted and paramedics arrived on scene at around 5:10am. Alex was found to have no pulse and he was tragically pronounced life extinct at 5:12am.

5.5 Attending NSWPF officers searched Alex's cell and found two lengths of cable ties on the floor. Each length consisted of three black nylon cable ties that had been joined together.

6. Post-mortem examination

6.1 On 8 February 2023, Dr Allan Cala, forensic pathologist, performed a post-mortem examination of Alex at Forensic Medicine Newcastle. This identified the following relevant findings:

- (a) distinct thin lines of pallor around the entire neck consistent with indentation from cable ties;
- (b) marked petechial haemorrhage formation evident in the upper and lower eyelids; and
- (c) toxicological analysis was negative for drugs and alcohol.

6.2 In the post-mortem examination report dated 28 April 2023, Dr Cala opined that the cause of Alex's death was asphyxiation due to cable tie compression of the neck.

7. Outcome of the NSWPF investigation

7.1 The NSWPF investigation identified that in February 2023, self-locking nylon cable ties were used at Junee for operational purposes including securing the lids on the milk containers delivered to accommodation units, sealing laundry bags, securing inmate property tubs, sealing service ducts and securing overalls worn during inmate visits.

7.2 It was identified that once milk containers are taken to accommodation units, the lids are open either by pulling up on the lid to break a cable tie or using tool such as scissors to cut the cable ties. Cut or broken cable ties are discarded in the general rubbish. However, the locking mechanism of a cable tie remains operational even after the cable tie is cut or broken, meaning that a cut or broken piece may be pulled through the locking mechanism. It was considered that Alex may have obtained broken or cut cable ties from the rubbish and been able to join several pieces together in a "daisy chain" to create a ligature of sufficient length.

7.3 On 5 and 6 February 2023, a direction was issued to all correctional staff at Junee to identify and remove all cable ties.

7.4 On 11 April 2023, a Joint Deputy Commissioner's Memorandum was issued for the information of all correctional staff and provided the following:

From 10/04/2023 Governors/Officer In Charge (OIC) of correctional centres and Managers of Industries must implement the following measures:

- Inmates are not to be issued with cable ties or have cable ties in their possession unless it is in the course of their employment and under staff supervision.
- Under no circumstances are inmates to have cable ties in their cell (Minimum Security centres and honour houses are exempt).

- Centres must implement control, monitoring, supervision, and accountability measures when issuing cable ties to inmate work crews, including the installation, removal, and disposal of cable ties to ensure they are accounted for daily, in every work location (as with industry tools and equipment).

7.5 Troy Seychelles, Governor of Junee, gave evidence that:

- currently at Junee cable ties are not used for the delivery of any rations, including milk containers;
- cable ties are stored in office locations that only correctional officers have access to and are *“accounted for in and out of that office”*;
- cable ties are used for laundry bags but are clipped so that there is no “tail” and after being removed from a laundry machine the mechanism holding the cable tie together is broken so that it cannot be used a second time;
- cable ties used to secure coveralls for inmate visitors are and following use are disposed of appropriately; and
- since commencing as governor on 1 April 2025, there have been no other incidents involving cable ties at Junee.

8. What issues did the inquest examine?

8.1 Before the inquest commenced, a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

- Between June 2021 and February 2023, did Junee Correctional Centre have appropriate policies and procedures in place regarding the mental health assessment of inmates following initial reception screening and inmate self-referral?
- Currently, does Junee Correctional Centre have appropriate policies and procedures in place regarding for the mental health assessment of inmates following initial reception screening and inmate self-referral?

9. Reception screening assessment

9.1 On 22 June 2021, Registered Nurse (RN) Gregory Bryon performed a Reception Screening Assessment (RSA) with Alex. The records of the RSA indicate the following:

- Alex reported previous diagnoses of schizophrenia and drug induced psychosis;
- Alex denied any thoughts of self-harm, any previous attempted self-harm and any thoughts of suicidal ideation; and

(c) Alex reported hearing (such as noises or the voices of people talking or whispering) and seeing things that other people could not hear or see.

9.2 Following the RSA, RN Bryon completed a Health Problem Notification Form which recorded the following under the heading, “*Signs/symptoms to look for in the inmate*”:

1st time incarcerated in NSW Previously incarcerated in Victoria
Covid swab Attended – follow covid protocol
One Out Cell Placement – due medical condition
Hx of Mental Health – Referred to Mental Health Team

9.3 RN Bryon gave evidence that based on the RSA he “*made a mental health referral for [Alex] to be seen as soon as he could within the five-day period and then he was referred to the doctor as well*”. RN Bryon explained that he used the Patient Administration System (**PAS**) to make the referral which required an inmate to be triaged so that a priority level could be assigned. Following referral, the inmate is placed on a waitlist. When an inmate is able to be seen, their name appears on a “*triage screen*” to inform a correctional officer of the need to take the inmate from their cell to their appointment.

9.4 RN Bryon also gave evidence that:

(a) he considered Alex’s case to be semi-urgent case that fell within a clinical level B patient category;

(b) it was his expectation that a semi-urgent case would be seen “*as soon as they can*” meaning, ideally, the next day; and

(c) he had no visibility over the waitlist and that he would not receive any notification or confirmation if an appointment was subsequently made.

10. Mental health assessment of inmates between June 2021 and February 2023

10.1 Following the RSA, the evidence established that an inmate at Junee could seek to access mental health services in the following ways.

Self-referral

10.2 First, an inmate could make a self-referral by completing a *Mental Health Request Form (MHR Form)*. The MHR Form is divided into two parts. An inmate completes the top half which asks for an indication whether an inmate is requesting to see a mental health nurse or a psychiatrist and for the inmate to describe the reason for the request. The bottom half of the MHR Form is used to record the date that the inmate is seen, nursing clinical notes and the outcome of the appointment or assessment.

10.3 The *Patient Self-Referral for Health Services – Medical Request Forms and Health Self-Referral Line* procedure (**Self-Referral Procedure**) contained in the Junee Correctional Centre Operating Manual relevantly provide the following:

Medical requests are designed for patients to request an appointment or request a health service. These forms should be used for non-urgent or routine matters only and are not required for urgent matters or for medical emergencies [...]

[...]

Forms are filled in by the patient and placed in the locked boxed [sic] in each accommodation area. These boxes are only accessible to nursing staff and must be cleared by nursing staff daily. The form may also be hand-delivered directly to any member of the health services team.

10.4 The Self-Referral Procedure goes on to provide the following steps to be taken:

Nursing staff who receive the form should review the form and determine the appropriate triage category and where the request should be directed.

[...]

Nursing staff will place the patient's request on the appropriate waiting list of PAS e.g., Primary Health Nurse, GP, Drug and Alcohol Nurse.

Nursing staff will complete the acknowledgement of receipt and this is to be returned to the patient's accommodation area in an envelope with their name and MIN [Master Index Number] as soon as practicable for distribution to the patient.

Nursing staff will make an entry into the progress note in JHeHS [Justice Health electronic Health System] to acknowledge receipt of the request.

10.5 Finally, the Self-Referral Procedure provides a table to be "*used as a guide for triage alongside clinical judgement and assessment*". This table indicates that patients "*who are stable but will require attention within 14 days to 3 months*" are considered to be non-urgent cases with a Priority Level 3.

10.6 Contained within Alex's patient records is a MHR Form completed and signed by him on 30 January 2023 (**January 2023 MHR Form**). In the form, Alex indicated his request to see a mental health nurse and described his reasons as follows:

I need to see mental health I have been waiting for a year and a half

10.7 The bottom half of the form has not been completed.

10.8 David Grace, the GEO Director of Health Services, gave evidence that it was his understanding that after a MHR Form was received and an inmate triaged and placed on an appropriate waiting list, the form would be destroyed. This is because a record of the triage and waitlist status would be kept on the PAS system. Mr Grace gave evidence that it was a matter of concern that the January 2023 MHR Form had not been destroyed and remained in Alex's patient records having not been completed by a mental health nurse.

10.9 The PAS appointment list for Alex contains an entry indicating that an appointment was made by RN Bernadette Barton on 16 September 2022 (**September 2022 PAS Appointment**) for Alex to be seen in the mental health nurse clinic. The comments attached to the entry indicate the following: "*Wanting a mental health assessment*". Under the heading, "*Attend/DNA*" the entry recorded is,

“Unspecified”. In addition, under the heading, *“Last modified by”* the entry recorded is, *“iie on 9 December 2022”*.

- 10.10 Mr Grace gave evidence that he would have expected a similar entry made in the PAS appointment list regarding the January 2023 MHR Form. However, the PAS appointment list contains no such entry. Mr Grace also gave evidence that he could not explain the entries under the headings, *“Attend/DNA”* and *“Last modified by”*.
- 10.11 RN Barton was one of two mental health nurses working at Junee between July 2022 and September 2023. She gave evidence that she created the September 2022 PAS Appointment. RN Barton also gave evidence that she also could not explain the meaning of the entry, *“Unspecified”*. However, RN Barton acknowledged it was possible that this meant that Alex could not be seen on 16 September 2022 due to the need for other inmates with a high priority category to be seen. RN Barton gave this evidence:

Okay, so the list is generated from a few different things. We try and look at our wait list. We try and start at the priorities, either 1, 2, 3, and we try and get those on the list for the particular day. Where it was very challenging was a lot of the times we could not get to that list. As I said, there was two of us, we were pretty much getting hammered every single day. We would create the list but that doesn't necessarily that [sic] list sticks for that day if that makes sense.

Sick parade

- 10.12 Second, both Correctional Officer (CO) Jennfier Shaw and Mr Grace gave evidence that during the daily “sick parade” conducted at Junee, an inmate could be taken to the medical clinic and inform healthcare staff directly regarding any health concerns. Depending on the nature and acuity of the concern, an inmate could be referred to the appropriate health service.
- 10.13 CO Shaw gave evidence that if an inmate was exhibiting behaviour or making comments indicative of thoughts of self-harm, a CO would remain with the inmate to ensure their safety until an Immediate Support Plan could be established.

Email referral from a correctional officer

- 10.14 Third, an inmate could approach a CO in their accommodation unit and seek help with accessing mental healthcare services. In response, a correctional officer could assist with provision or completion of a MHR Form, or send an email or make a phone call to the mental health team. In response, a member of the mental health team might contact the referring CO to seek information regarding the urgency of the request and how soon an inmate needed to be seen.
- 10.15 CO Katherine Read gave evidence that on 31 January 2023, she received a phone call indicating that Alex’s mother had called requesting a welfare check for Alex. In response, CO Read attended Alex’s accommodation unit where she spoke to Alex. CO Read gave this evidence regarding her conversation with Alex:

So once we started that conversation, I just said how are you going and everything, and he did mention something about his mental health and stuff so that's when I asked him - that's when we

got into conversation how you doing. I did ask him has he got any thoughts of self-harm and did offer to take him up to medical.

10.16 CO Read gave evidence that Alex said that he “*wanted a referral for his mental health*”. CO Read explained that Alex declined the offer to be taken to the medical centre, said he was “*fine*”, and walked off. CO Read also gave evidence that she did not observe anything different from Alex’s usual behaviour or demeanour.

10.17 CO Read gave evidence that following her interaction with Alex she:

- (a) called the mental health team and spoke with a nurse;
- (b) was told that she could not be provided with any information regarding when, or how soon, Alex could be seen by a mental health nurse;
- (c) was told that someone would “*get back*” to her; and
- (d) subsequently told Alex that she had made a phone call to the mental health team on his behalf and the outcome of that call.

10.18 On 2 February 2023, CO Read sent an email (**February 2023 Email**) addressed to “JCC Mental Health Team” with Alex’s surname and MIN in the subject line which contained the following:

Good Morning

The above inmate would like to speak to mental health he said he is struggling at the moment, and we also received a [sic] outside phone call from his Mother stating her concerns.

Have a great day

10.19 CO Read gave evidence that she sent the February 2023 Email in accordance with a direction given to correctional officers. CO Read gave evidence that “*it was just the process that we had to follow back then*” but could not recall when the direction was given, how it was communicated or by whom. CO Read explained:

I just think at that time the mental health team were quite short. There's only two -by my memory, there was two mental health nurses to a whole gaol, so if -maybe that's how they thought they would manage it better, I don't know. I can't speak on behalf of them, but that's what we were told to do - is just email, if needed.

10.20 CO Read gave evidence that she could not recall receiving a return call from anyone in the mental health team and that it was usual to receive a call back but “*it just depends how busy they are at the time*”. CO Read also gave evidence that after 2 February 2023, she had some rostered days off but that if she had not received a response by phone or email upon her return she “*would’ve just followed up on it or called them again*”.

- 10.21 RN Barton gave evidence regarding her usual practice upon receiving an email from a CO regarding an inmate referral to the mental health team:

Yep, we look at the email, we see what the issue is. We normally try and ring and speak to the officer whoever did the referral, just to find out a little bit more information. At that point we either make a plan of do we bring them up, see them, or how urgent it may be. We would also get some collateral from the correctional officers if not listed in the emails.

- 10.22 RN Barton also gave evidence that the February 2023 Email should have been recorded on JHeHS and that its contents indicated a semi-urgent presentation. RN Barton was taken to the PAS Waitlist which indicates that on 7 April 2022, Alex was placed on the waitlist to be seen at the June Mental Health Nurse Clinic with a comment entry, “*Wanting a mental health assessment*”. The PAS Waitlist also indicates that Alex had been on the waitlist for 309 days (although there were actually 305 days between 7 April 2022 and 5 February 2023) and that he had been assigned a Non Urgent Priority 3 category.
- 10.23 RN Barton gave evidence that a wait time of 309 days was “*a fairly typical presentation for a semi-urgent consult*”. RN Barton also gave evidence that if a mental health nurse had been able to see Alex he would be assessed and if he needed to be seen by a psychiatrist he would be placed on a further waitlist. RN Barton described the psychiatrist’s waitlist to be “*fairly hefty*” and that the nurses needed to prioritise which inmates needed to be seen.

Phone referral from a correctional officer

- 10.24 Fourth, apart from sending an email to the mental health team, a CO could also call on behalf of an inmate seeking a mental health assessment. As noted above, on 13 January 2023, Alex wrote in his diary: “*seen ms connors at Enq and asked her to chase up mental health*”.
- 10.25 CO Coralie Eley Connor was working as a Correctional Supervisor at June on 13 January 2023. She gave evidence that it was her practice to run “Enquiries” each weekday morning which involved going into an accommodation unit with a notebook known as the Inmate Enquiry Diary (IED) and various forms. CO Eley Connor explained that inmates would then line up and make certain requests. CO Eley Connor gave evidence that she would provide inmates with forms relating to the requests or note down details of their requests in the IED for subsequent follow-up.
- 10.26 CO Eley Connor gave evidence that during Enquiries on 13 January 2023, Alex asked her to follow-up on previous requests that he had directed to the mental health team, together with previous requests related to his dental and medical health (**January 2023 Enquiries**). CO Eley Connor gave evidence that Alex did not provide any information regarding the nature of his requests or the reason for them. Following her conversation with Alex, CO Eley Connor recorded the following entry in the EID:

Gavranic – medical requests? MH.

10.27 CO Eley Connor gave evidence that she:

- (a) called the mental health team to follow-up on Alex's requests but could not recall who she spoke to;
- (b) she was advised that Alex's requests had been received and that he had been placed on a waitlist;
- (c) was not provided with any estimate as to when he might be seen;
- (d) later on 13 January 2023, returned to the accommodation unit and updated Alex regarding her conversation;
- (e) she observed no signs during her interactions with Alex that he was in obvious distress and that he had not expressed any thoughts of self-harm; and
- (f) would have immediately escorted Alex to a camera holding assessment, conducted a risk assessment and formulated an Immediate Support Plan if he was observed to be in distress or had expressed thoughts of self-harm.

10.28 CO Eley Connor also gave evidence that she did not document the enquiries that she made on behalf of Alex or the outcome. CO Eley Connor explained:

If somebody had approached me and said that they were struggling with their mental health, or that they had thoughts of self-harm or suicide, it would, it would, it would be noted. It would be case noted and that sort of stuff. But if an inmate has approached me and said that they need to speak to mental health, and they often do. This is something that happens all day long, every day.

10.29 Adam Vance, the Justice Health Nurse Manager for Clinical Operations for Mental Health, gave evidence that currently if a Justice Health clinician received an email or phone referral from a CO regarding an inmate, the following would be expected:

It'd be having a dialogue with the referrer, clarifying information and then they would either make a progress note and discuss it with the mental health nurse to see what's the course of action here or they'd make a progress note and also make that referral.

10.30 Mr Vance also gave evidence that he would expect a Justice Health clinician to document the nature of any conversation with the referring CO, what information was provided, other sources of information considered by the clinician, the outcome of the conversation, and any plan formulated.

10.31 Further, Mr Vance gave evidence that from the perspective of Justice Health, it would be possible for an inmate's initial priority category to be reassessed and changed while waiting for assessment or treatment. He explained:

[I]t's about new information or it's about changing health status really. So if someone has contacted us and provided - seeking an update, for example, when are they going to be seen and they provide

you information that indicates there's a deterioration since the initial triage, then that would absolutely be grounds for increasing the priority or, you know, seeing them - seeing them immediately in some cases. So, yeah, new information, changed health status or, you know, changed circumstances.

Offender Integrated Management System

- 10.32 Fifth, correctional staff (including correctional officers and SAPOs) could submit requests on behalf of inmates through the CSNSW Offender Integrated Management System (**OIMS**). However, this type of request was limited to referrals to a psychologist or to counselling.
- 10.33 Christopher Olson, the CSNSW Manager of Security of State-wide Operations, gave evidence that it was not possible to make a referral through OIMS to Justice Health including for an inmate to be seen by a mental health nurse or psychiatrist. This is because, OIMS and JHeHS did not share cross-platform compatibility.

Requests initiated by family members

- 10.34 Sixth, as demonstrated by Patricia, family members could raise concerns directly with June. As described above, Patricia's call to June on 31 January 2023 requesting mental health assistance for Alex resulted in CO Read speaking with Alex. In her statement, Patricia stated that she had observed Alex displaying paranoid and delusional behaviour and that she had "*deep concerns for his safety due to his obvious mental health crisis being ignored*". Patricia accordingly pleaded with Alex to ask to see a doctor for mental health care and tried to advocate on his behalf. She stated:

On 31 January 2023, I called a number that I thought was to an office higher up than June gaol, as I desperately wanted to get Alex a mental health assessment and care. I wanted to get him something to help him. Just talking to him, I knew he'd gotten to the point where he wasn't coping. He said, "You've got no idea, Mum, how hard this is. I've never done anything so hard in all my life".

- 10.35 **Conclusions:** The evidence demonstrated that between June 2021 and February 2023, several pathways were generally available to an inmate at June to seek access to mental healthcare services. Some of these pathways were utilised by and for Alex so that he could be seen by a mental health nurse.

- 10.36 These pathways included the referral made from the initial RSA, the September 2022 PAS Appointment, the January 2023 Enquiries, the January 2023 MHR Form, the call from Patricia on 31 January 2023, and the February 2023 Email. Regrettably, none of these pathways actually resulted in Alex being seen by a mental healthcare professional. Indeed, it is entirely unclear on the available evidence how the September 2022 PAS Appointment came to be made and why the January 2023 Enquiries, the January 2023 MHR Form or the February 2023 Email failed to result in any meaningful steps being taken to progress the requests made by and on behalf of Alex.

10.37 Given the transition in the management of Junee from GEO and GEO Healthcare to CSNSW and Justice Health respectively, and limited access to records available at the time, it has not been possible to identify any precise reason why Alex was not seen by a mental health nurse. The coronial investigation was unable to identify the clinicians who received each referral or request and accordingly the inquest received no direct factual evidence regarding any steps taken, if any, beyond the point of referral or request.

10.38 Further, the available evidence indicates that the requirements of the Self-Referral Procedure for a receipt of a referral to be acknowledged and properly documented were not complied with. It may be inferred that one possible contributing factor was the significant inmate demand placed upon limited healthcare resources. This is a matter discussed in more detail below.

10.39 However, the evidence also indicates that several aspects of the request or referral process contributed to the lack of mental healthcare access for Alex. First, the request or referral pathways utilised by and for Alex were fragmented. Verbal enquiries and requests were not documented and consequently were not linked to enquiries and requests made in writing or by email. Second, despite indications being given that the January 2023 Enquiries and the phone call by CO Read would result in a response, none was provided. Third, no system existed for the absence of any response to the requests and referrals being followed up. Fourth, it does not appear that the repeated requests and referrals made by and on behalf of Alex were recognised or that the repetition might suggest a need for Alex's priority to be reassessed. However, it is acknowledged that apart from the repetition itself, the actual requests and referrals did not explicitly disclose any change in Alex's circumstances or health status.

10.40 Ultimately, it is not possible to reach any conclusion as to what the outcome might have been if Alex had been seen by a mental health nurse. It may have resulted in some form of treatment being provided. Alternatively, Alex may have been placed on a further waitlist to be seen by a psychiatrist. However, given the speculative nature of these matters means that no positive conclusion can be reached that access to mental health care would have resulted in a different outcome for Alex.

10.41 Notwithstanding, the wait of at least 305 days experienced by Alex far exceeded the maximum 3 month timeframe contemplated by the Self-Referral Procedure for an inmate with Alex's Level 3 Priority. The inability of Alex to access mental healthcare services within this timeframe likely caused distress and deterioration of his mental well-being and represented suboptimal care. However, it is acknowledged that the evidence given by correctional officers is that no visible signs of distress were observed in Alex and that he made no references to thoughts of self-harm in his interactions with the officers so that an immediate risk assessment or further steps were required.

11. Mental health assessment of inmates currently

11.1 In addition to the pathways described above, one additional method by which an inmate may seek to access mental health services is through an Offender Tablet (**OTAB**). Governor Seychelles gave evidence that an OTAB can be used to access the Common Auto Dialler (**CADL**). This is a phone referral service which an inmate can use during business hours to request healthcare assistance from Justice Health.

11.2 In addition, Governor Seychelles also gave evidence that an inmate can use the Corrective Services Support Line (**CSSL**) which is another way to make a phone request to Justice Health through the CADL. Further, Governor Seychelles explained that phones are located in accommodation areas in Junee and inmates are able to use the CSSL to request assistance in this way.

11.3 Finally, Mr Olson gave evidence that an inmate may use an OTAB to submit an electronic grievance form indicating, for example, that they have been waiting to be seen by a healthcare service following an initial request. Mr Olson gave evidence regarding the way in which this process is documented.

So, with the OTAB, the entry will stay open until it's dealt with, and once that complaint or the grievance has been dealt with, the area manager or the supervisor will close that off and it'll be an electronic record showing it's closed. If there's a referral or a further action that is required, a case note will be entered on OIMS as well, to record that activity.

11.4 Section 9.1 of the CSNSW Custodial Operations Policy and Procedures (**COPP**) provides for inmate application and requests. Subsection 3 provides:

The accommodation supervisor will check OTAB Command each day to ensure requests are managed within appropriate timeframes and will escalate any requests not actioned within 14 days to the [Functional Manager] where appropriate.

11.5 Subsection 3 also provides that where an inmate submits a paper request form, this will be recorded on a register and the Functional Manager will review the register daily to assess the progress of pending requests and, “*wherever possible, ensure [the] request is finalised within 14 days of issue*”.

11.6 Mr Olson gave evidence that if an inmate approached a CO requesting assistance to see a mental health nurse, this would not be documented. As a result, escalation or review of the request would not occur in the same way as for a request submitted through OTAB or a paper request recorded on a register.

11.7 **Conclusions:** The evidence demonstrates that at least since February 2025, inmates at Junee have an additional pathway available to them by way of an OTAB to request access to mental healthcare services. Further, relevant provisions of the COPP provided for the documentation of inmate requests made on an OTAB or paper form so that the request can be escalated to a senior correctional officer if not actioned within 14 days. However, the evidence indicates that similar documentation and escalation does not occur when an inmate approaches a CO seeking assistance with accessing mental health services. Accordingly, it is necessary to make the following recommendation.

11.8 **Recommendation 1:** I recommend to the Commissioner of Corrective Services New South Wales that guidance or instructions be provided to correctional officers regarding the need to thoroughly document any request made directly by an inmate to a correctional officer for assistance with accessing mental healthcare services. This is so that if the request is not actioned in a timely manner, appropriate follow-up and escalation of the request to a senior correctional officer can occur.

11.9 The Coronial Advocate submitted that a recommendation should be made that CSNSW and Justice Health develop or formalise a process by which repeated requests or referrals for inmate access to mental health services trigger consideration of whether an inmate's clinical priority should be reviewed. It should be noted that Justice Health was not a sufficiently interested party at the inquest and therefore did not have an opportunity to make submissions in reply. Further, any existing applicable Justice Health clinical guidelines or protocols were not received or considered by the inquest.

11.10 However, the evidence of Mr Vance broadly indicates that where repeated requests or referrals indicate a change in an inmate's health status suggestive of deterioration, Justice Health clinicians are expected to consider the need for a change in the inmate's priority or a need for the inmate to be seen by a mental health care professional immediately. Therefore, it is neither necessary nor desirable to make such a recommendation.

12. Availability of resources

12.1 One topic canvassed with several witnesses during their evidence in the inquest concerned the availability of resources for the inmate cohort.

12.2 Ms Barton gave evidence that during the period she worked at Juneee:

- (a) she and another mental health nurse worked from 7:30am to 4:30pm, Monday to Friday;
- (b) a visiting psychiatrist attended "*a couple of days a month*";
- (c) there were over 400 inmates, which was approximately half of the inmate population at the time, waiting to be seen by a mental health nurse;
- (d) lower priority cases were frequently displaced by more urgent cases (such as where an inmate was in acute distress or an inmate had threatened or performed self-harm) meaning that daily appointment lists were not always completed;
- (e) there were not enough nurses to meet the needs of the inmate population and she said that she and her fellow mental health nurse "*barely scratched the surface*";
- (f) any mental health problems that inmates were experiencing would continue because they could not be seen or reviewed by a mental health nurse and that there were "*a lot that fall through the cracks of the system as it was at that stage*"; and

(g) given the matters referred to above she agreed that Junee was an unsatisfying place to work.

12.3 CO Eley Connor gave evidence that in the period between 2021 and 2023:

- (a) there were only two mental health nurses servicing an inmate population that fluctuated between 700 and 1000;
- (b) a psychiatrist attended approximately one day per week, seeing around five or six inmates each time;
- (c) her expectation was that there would be “*many months*” between triage and an inmate being seen by the psychiatrist; and
- (d) the demand for mental health care at Junee was “*huge*” and “*phenomenal*”.

12.4 Mr Vance gave evidence:

- (a) confirming that Junee had two mental health clinical nurse specialists working from Monday to Friday;
- (b) confirming that a visiting psychiatrist attended two days per fortnight;
- (c) that the staffing profile of the mental health team and Junee currently is essentially “like for like” following the transition from GEO Healthcare to Justice Health;
- (d) that the resourcing remained unchanged “*as far as people on the ground*”;
- (e) that “*healthcare demand in custody exceeds the resources that are available*”; and
- (f) the funding provided “*typically doesn’t meet demand*”.

12.5 Governor Seychelles gave evidence that:

- (a) the pressure on mental health services and the availability of such services currently remains the same as the period when Junee was managed and operated by GEO;
- (b) there are “*quite possibly*” many members of the inmate population who are not accessing services that they need for their mental health;
- (c) the funding for mental health care within Junee is inadequate;
- (d) more mental health nurses are needed to provide a level of care for inmates commensurate with what people in the community are able to access;
- (e) the resources, including the budget, allocated to Junee (and, indeed any correctional centre) limits the “*capacity to address every single need that is raised in the centre on each day*”; and

(f) the inmate population at Junee was 746 in September 2026 and due to increase to 944 in October 2026, with a maximum capacity of 1280.

12.6 Counsel for the Gavranic family submitted that the evidence in the inquest demonstrated “*a system in crisis*” with mental health care resources being insufficient to meet the demands of the inmate population at Junee. It was submitted that “*there is some artificiality*” in seeking to improve the pathways by which a mental health referral might be made for an inmate if there is no reasonable prospect that such a referral will result in timely care being provided. Accordingly, it was submitted that a recommendation ought to be made that CSNSW and Justice Health consider how to improve funding to allow for more mental health nurse and psychiatrist full-time equivalent positions.

12.7 **Conclusions:** There is force to the submissions advanced by Counsel for the Gavranic family. Several witnesses working on the ground at Junee gave frank evidence that demand for adequate mental health care for inmates at Junee is significant and that such demand exceeds the available resources. The evidence also established that this imbalance resulted in excessively long wait times that far exceeded the clinical timeframes applicable between 2021 and 2023. This in turn contributed to the continuation, and possible exacerbation, of untreated mental health issues in inmates whilst waiting to be seen by a healthcare professional. With the inmate population at Junee expected to only increase, the disparity between demand and available resources is likely to only worsen.

12.8 It is unsurprising to observe that the limited availability of resources within public services is a theme which pervades many inquests. It is equally unsurprising that such resourcing is tied to finite funding and budgetary constraints within the public sector more broadly. These are complex, multi-faceted issues which are beyond the scope and capacity of this inquest to meaningfully examine. This inquest received no evidence regarding any aspect of the manner in which funding is allocated and the considerations which apply to such a process. As Governor Seychelles readily acknowledged in his evidence, there is no simple answer to such a complex problem.

12.9 The observations above are made in the hope that repetition will continue to highlight the deficiencies that this inquest has demonstrated regarding the provision of mental health care to persons in custody and the need for further review, if not meaningful change. Making a broad recommendation that more funding should be allocated to the provision of healthcare services within the correctional system risks re-stating what is plainly obvious and is too simplistic to be practical or effective. However, it is desirable to make the following recommendation in the hope that it may have a more practical effect.

12.10 **Recommendation 2:** I recommend to the Governor of Junee Correctional Centre that the findings of this inquest be used to advance the position before any future funding or budgetary allocation process that the staffing profile of mental healthcare services at Junee Correctional Centre be increased so that the significant demands of the inmate population for such services are adequately met.

13. Findings

13.1 I acknowledge, and express my gratitude to Ms Alison Storm, Coronial Advocate Assisting the Coroner, for the assistance provided throughout the coronial investigation and inquest, and the sensitivity shown to Alex's family.

13.2 I also thank Detective Sergeant Kerry Bartlett for her role in the NSWPF 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 Alexander Gavranic.

Date of death

Alexander died on 5 February 2023.

Place of death

Alexander died at Junee Correctional Centre, Junee NSW 2663.

Cause of death

The cause of Alexander's death was asphyxiation due to cable tie compression of neck.

Manner of death

Alexander died whilst being held in lawful custody at Junee Correctional Centre as a result of actions taken by him with the intention of ending his life. He died in circumstances where he had been on a waitlist for at least 305 days to access mental healthcare services with no such services provided. However, it is not possible to determine whether access to such services prior to 5 February 2023 would have materially altered the eventual outcome.

13.4 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my sincere and respectful condolences to Alex's family, loved ones and friends for their tragic and devastating loss.

13.5 I close this inquest.

Judge Derek Lee
Deputy State Coroner
14 October 2026