CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Fredrick Elrezz
Hearing dates:	1,2,3,10,11,12, 25 June 2026
Date of Findings:	10 July 2026
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge David O'Neil, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW – responsibilities of police officers to whom suicidal thoughts are reported by person in custody, relaying of information from NSW Police to Corrective Services NSW – Reception Screening Assessment – communication between Corrective Services NSW and St Vincents Correctional Health at Parklea Correctional Centre
File number:	2020/279909
Representation	Mr M Robinson as Counsel assisting, instructed by Ms L Shepherd of the Crown Solicitor's Office Mr A Mykkeltvedt for Office of the General Counsel, New South Wales Police Force Mr T Hackett for MTC-Broadspectrum M J Harris for St Vincents Correctional Health Ms M O'Brien for Corrective Services New South Wales Mr B Haverfield for Constable M Dut Mr W Bruffey for Constable G Kaya and Sergeant D Plane Mr D Nagle for Constable S Kirk Mr W Wilcher for Sergeant D Cox, UCO508 and UCO675
Non-publication orders	Non-publication orders made pursuant to s 74 of the *Coroners Act 2009* and/or the incidental powers of the Court apply in this matter and are available on the Court file. Copies are also annexed to these findings.

Findings:

The identity of the deceased

The person who died was Fredrick Elrezz

Date of Death

Fred died between 3:08 pm on 24 September 2020 and 8:16 am on 25 September 2020

Place of Death

Fred died at Parklea Correctional Centre, Parklea, New South Wales

Cause of death

Hanging

Manner of Death

Deliberately self-inflicted

Recommendations

I make the following recommendation pursuant to s 82 of the *Coroners Act 2009* (NSW)

To the Commissioner of Police NSW:

I recommend that the New South Wales Police Force Handbook chapter titled "*Custody*" and the Charge Room and Custody Management Standard Operating Procedures to impose an obligation on any officer who comes to learn (whether through their own observation or through information passed to them by a colleague) of anything that indicates that a person in police custody is at increased risk of self-harm or suicide (for example, where they make statements indicating an intent to self-harm), either to communicate that information to the Custody Manager themselves, or to satisfy themselves that it has been so communicated.

Introduction

1 Fredrick Elrezz, whom the family have requested be referred to as Fred, was born in Melbourne in 1988. In September 2020 he was found hanging in his cell at Parklea Correctional Centre, he was aged 32.

2 Because Fred died while in custody, an inquest is required by the *Coroners Act 2009* (NSW).

3 When someone is in lawful custody, they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases, the community has an expectation that the death will be properly and independently investigated.

The Inquest and the Coroner's role

4 An inquest was held between 1 and 12 June 2026, at the Coroners Court of New South Wales, Lidcombe. The inquest ran partly concurrently and partly consecutively with the inquest into the death of CG.

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate adverse comment or criticism to be made.

6 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act, being the person's identity, the date and place of the person's death, and the manner and cause of the person's death.

7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

8 Prior to holding the inquest, a detailed coronial investigation was undertaken and the Officer in Charge of the investigation (OIC), Detective Senior Constable Antonio Henriquez compiled an initial brief of evidence comprising a number of documents, including a report by a forensic pathologist as to the cause of death. The court also received extensive documentary material which included witness statements, medical records, and policies and procedures.

9 All the documents including witness statements obtained during the coronial investigation formed part of the eight-volume brief of evidence that was tendered at the commencement of the inquest. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, have been considered in making the findings detailed below.

Sufficient Interest Parties

10 The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

(1) The family of Mr Elrezz

(2) The Office of General Counsel, New South Wales Police Force

(3) The Commissioner, Corrective Services NSW (CSNSW)

(4) MTC-Broadspectrum

(5) Justice Health and Forensic Mental Health Network (did not seek leave to appear at inquest)

(6) St Vincent's Correctional Health

(7) Constable Madeng Dut.

(8) Constable Gokhan Kaya.

(9) Constable Sam Kirk.

(10) Sergeant David Cox.

(11) Sergeant Daniel Plane.

(12) UCO508 "Adam".

(13) UCO675 "Zac"

Witnesses

11 The following witnesses gave evidence at the hearing.

(1) Constable Madeng Dut

(2) Constable Sam Kirk

(3) Constable Gokhan Kaya

(4) Sergeant David Cox

(5) Sergeant Daniel Plane

(6) UCO508 "Adam"

(7) UCO675 "Zac"

(8) CIN 1715

(9) Shantanu Rastrapal

(10) Tania Nguyen

(11) Megan Lawlor

(12) Correctional Officer Nikhil Marwaha

(13) Correctional Officer Suman Chapagain

(14) Registered Nurse Julie Dyer

(15) Superintendent Raymond Peter Stynes

(16) General Manager Statewide Operations Security and Custody for Corrective Services New South Wales, Malcolm Brown

(17) Executive Director, Strategy, Contracts and Commissioning for Corrective Services New South Wales, Craig Mason

(18) Former Governor of Parklea Correctional Centre, Wayne Taylor

(19) Representative for St Vincents Correctional Health, Nicola Smith

Issues considered in the Inquest

12 An issues list was distributed to the parties as guidance as to the issues to be considered at inquest.

13 An issues list is neither determinative nor limiting. In the inquest further issues arose which will be dealt with later in these findings. The issues set out in the issues list were:

Issue 1

The adequacy of the manner in which expressions of Fred's suicidality were documented and communicated by NSW Police to CSNSW.

Issue 2

Whether Fred's mental health was adequately assessed by NSW Police while in police custody in September 2020, and whether the information they obtained was adequately shared with CSNSW.

Issue 3

Whether MTC-Broadspectrum or St Vincents Correctional Health knew that Fred's intention on 2 September 2020 was to die, and whether knowledge of that matter would have altered his management at Parklea Correctional Centre.

Issue 4

Whether Fred's cell placement decision, including the decision to place him in segregation and in a one-out cell, was appropriate having regard to information known about him, or reasonably capable of being ascertained, both at the time of his reception into custody and during the period of his incarceration thereafter.

Issue 5

Whether any recommendations are necessary or desirable in relation to any matter connected with the death.

Personal Background

14 Much of the background information which follows was provided by Fred's sister, Tanise, who attended throughout the inquest.

15 Fred was an Australian citizen who grew up in Melbourne. Fred's childhood was marked by significant instability.

16 Tanise indicated the following:

(1) Home life was tense and at times unhappy.

(2) Fred witnessed many conflicts between his parents, and at times had to become involved in physical situations to defend his mother.

(3) Fred was subjected to physical and emotional abuse from the age of six, including being struck with brooms, sticks and fists.

17 Fred drank alcohol, smoked cannabis, and experimented with other drugs from the age of 15. After a period of custody when he was aged about 17, Fred took his father on physically in a violent fashion. Fred told counsellors that his mother separated from his father shortly after that incident.

18 Fred was physically violent towards fellow students at times during his studies at school and TAFE. He completed year 12 and attained certificates in business and

general education for adults, and also studied food safety and kitchen hygiene. Post school, Fred worked in retail, telephone sales, factory work and labouring.

19 Having left home at 14, Fred lived with friends and their family or on the street for months at a time before returning home for periods. Fred had numerous court attendances for assault, theft, burglary, stolen goods, and possess cannabis.

20 When Fred's mother separated from her husband, she moved to Queensland. Subsequently, Fred, and on occasions he and Tanise together, lived with relatives or their mother. At other times Fred and Tanise each lived independently, whilst at other times in his late 20s and early 30s, Fred was incarcerated on occasions.

21 In September 2019, while Fred was in custody at the Silverwater Correctional Complex, his mother died. He was released on parole some weeks later in or about November 2019. Following his release, Fred returned to Melbourne to live with Tanise, who describes him as having initially seemed mentally well. On or about 27 December 2019, Fred told her that he had been prescribed mood stabilisers, but felt he no longer needed them and intended to cease taking them.

22 Through the early months of 2020, Tanise describes a progressive deterioration in Fred's mental state. He began to display emotional dysregulation and outbursts of distress. He became increasingly paranoid, expressing the belief that the government was watching him and that members of his own family were conspiring against him. He changed his name on social media on more than one occasion because he believed that he was being surveilled.

23 After Tanise returned home from a brief trip to New Zealand in February 2020, she found Fred in the family home with the windows jammed shut, the blinds drawn, and a knife in his hand.

24 In late April 2020, Fred sent a sequence of Facebook Messenger messages to Tanise, which included:

> *"I'm going to get life insurance, put it under your name just in case anything happens to me. I want to get life insurance, if anything happens to me, you get it, but if I go for instance go to jail, worst case scenario, could you pay it, maybe 40 a month? I'll keep some money*

in my account, just make sure it gets paid if I go away. Yes or no, I'm doing it tomorrow"

25 Tanise's last contact with Fred was on 14 June 2020. She first learned of his arrest in September 2020 from a media report. She thereafter made repeated attempts to make contact with Fred through his lawyer and through Parklea Correctional Centre without success.

26 Fred's acquaintance, Mr Mohammed, was often in Fred's compamy from late May 2020 until early August 2020. Mr Mohammed informed police that during that period Fred appeared paranoid and that he was concerned about Fred's declining mental health and mood swings.

27 Fred told Mr Mohammed that he had found Islam, although Mr Mohammed did not observe any signs of radicalisation. Mr Mohammed is a gentleman of Ethiopian background. He first met Fred at the end of May 2020 in a hostel in Adelaide. He regularly saw Fred around the hostel in the kitchen and the common area over a period of about three weeks. Fred told Mr Mohammed, *"he had it rough in the past".*

28 Mr Mohammed said that Fred liked dancing and wanted to become famous. Fred used to record himself singing and dancing in Facebook posts. On 16 July 2020, Fred and Mr Mohammed travelled from Adelaide to Melbourne to Sydney by bus. Mr Mohammed observed Fred to, on occasions, suffer delusions, and at other times Fred showed signs of paranoia.

29 Mr Mohammed ceased contact with Fred around the beginning of August 2020 as he had concerns about Fred's mental health and his inconsistent demeanour and mood swings.

Events on 1 and 2 September 2020

30 On the evening of 1 September 2020 into the early hours of September 2, Fred was on George Street Sydney. He was observed by members of the public to be aggressively singing or rapping on the footpath and breathing heavily.

31 He looked at a group of people in a manner one witness later described as if he wanted to kill someone, and then allegedly punched an unknown male in the face. A police

broadcast was issued to keep a lookout for Fred. Officers from New South Wales Police located Fred a short time later. During the course of their interaction with him, Fred struck a police officer in the head with a knife, causing a laceration. He also bit a police officer before being restrained.

32 He was thereafter charged with a number of offences including resist or hinder police officer in the execution of duty, wound person with intent to resist or prevent arrest, cause wounding or grievous bodily harm to person with intent to murder, and assault police officer in the execution of duty causing actual bodily harm.

33 Fred was taken into custody at Day Street police station at about 12.50am on 2 September 2020. As was required, the custody manager at Day Street, Sergeant Cox, completed a custody management record at around 1.15am. A questionnaire which forms part of the custody management record included the following questions:

"Q. Have you ever tried to kill yourself?"

A. No.

Q. Do you have a history of, or do you currently have, a mental illness?

A. No."

34 Consistent with the responsibilities of a custody manager, Sergeant Cox had to set out the frequency of observations of Fred. Fred was to be observed at least every 60 minutes. At approximately 2.40am on 2 September, ambulance officers attended upon Fred when Fred had complained of a sore left hand. On assessment, the ambulance officers found the hand injury to be minor, and Fred was provided two Nurofen tablets.

35 In their written report, the ambulance officers noted "patient does not present with any concerning medical observation at time of assessment." Specified observations included pulse, temperature and a notation that verbal responses were appropriately orientated. All Fred's vital observations were normal. At 3.09am, Sergeant Cox thought that Fred appeared to be slightly affected by alcohol. A note indicates:

> *"Fred appears coherent and able to understand all conversation with police and the ambulance officers but his mannerisms and body language appear slightly*

sluggish, which does indicate that he could slightly be affected by alcohol or an illicit drug."

36 However, at 4.10am a further note reads "*does not appear intoxicated, clearly spoke to custody manager, walks normally when allowed to go to the bathroom*."

37 Sergeant Plane took over from Sergeant Cox at approximately 5am on 2 September. Sergeant Barlow later took over as custody manager from 9pm. The custody management record reveals that during Fred's time in custody he spoke to a lawyer on at least two occasions. At 10pm on 2 September, Fred was transferred from police custody to Corrective Services New South Wales custody located in Surry Hills in anticipation of a court appearance the following day.

38 During the period in police custody just described, various police officers heard Fred make the following comments in relation to his suicidality.

39 Constable Kirk, who had been in the job 18 months at the time, heard Fred say to another person in custody "*I stabbed them, I wanted them to shoot me*." Constable Kirk relayed these comments to plainclothes police officers involved in the investigation of what had occurred previously.

40 In addition, Constable Kirk made a note of what he had heard, both as a record of suicidal intent and for the purposes of the investigation that was being undertaken. Constable Kirk could not recall if he did or did not tell the custody manager but emphasised that he did tell detectives, as he thought they may want to schedule Fred.

41 Constable Kirk understood the custody manager would do his own assessment. He now understands, as I will shortly develop, that he should have told the custody manager.

42 It was the clear evidence of Sergeant Cox that he was not ever told that Fred had expressed any thoughts of suicide. No police officer, including Constable Kirk, reported such expressions to Sergeant Cox.

43 Constable Dut, who had conveyed property from the scene back to Day Street, also heard comments made by Fred to another person in custody. He noted that Constable

Kirk told him to make a note of what he had heard. Constable Dut made a note on a piece of paper. Relevantly, what Constable Dut heard included

> *"I just want to end it. I went to stab a copper so that they can shoot me, but they didn't. I stabbed a copper and they didn't spray me, tase me or anything. I'm surprised they didn't even break my legs, nothing."*

44 Probationary Constable Kaya who had been sworn in 15 days previously, was in attendance at the Day Street station, assisted taking property from the scene. He heard Fred say:

> *"I think the police follow me around. I'm going to hang myself when I get to gaol. Police harass me 'cause I'm Muslim. I thought the officers would draw their firearm when I drew my knife or at least used a taser or the pepper spray."*

45 He later heard Fred say, *"I stabbed a cop in the head."* Neither Constable Dut nor Probationary Constable Kaya as they were at the time reported what was said by Fred to the Custody Manager.

46 Later other police officers interviewed Fred and Fred spoke separately with undercover operatives (UCOs). During those exchanges Fred indicated he *wanted to die,* he *wanted to get it over and done with* and he *wanted to get shot.* More than one of those officers accepted the proposition that Fred wanted, in effect, to commit suicide by cop.

47 Additionally, one of those officers who interacted directly with Fred formed the view Fred was mentally ill whilst another formed the view Fred suffered from paranoia.

48 The evidence was that those police officers had a debrief following their interactions with Fred. The debrief included at least some of the investigators, a Detective Senior Constable and an Inspector, variously referred to as a Detective Chief Inspector or a Detective Inspector.

49 The UCOs were of the view the investigators were well aware of Fred's perceived mental illness or paranoia and suicidal comments and assumed the investigators would pass that information onto the custody manager. It was not disputed that each police officer individually owed Fred a duty of care. Each thought some other officer would advise the Custody Manager of what Fred had said. No police officer did so.

50 Sergeant Plane gave evidence that he would expect any police officer who had heard any one of the comments attributed to Fred to have reported it to him in his role as custody manager. I accept those comments; however, I do note there may have been good practical reasons why the UCOs could not have done so directly.

51 It was common ground amongst Sergeants Cox and Plane and Superintendent Stynes that if the information had been passed onto any of the custody managers, they would have made arrangements for ambulance officers to attend upon Fred to assess him, and if the ambulance officers did not use their powers under mental health legislation to refer Fred to hospital for assessment, then the sergeants would have used their power to do so.

52 If a hospital assessed Fred to be mentally ill, he would have remained in hospital until cleared. If the hospital assessed Fred to not be mentally ill, under the relevant legislation, there would have been no need to detain Fred for the protection of himself or others from serious physical harm. If that was the assessment made, then the hospital would have completed appropriate paperwork which would have cleared Fred to be in the custody of NSW Police and/or Corrective Services NSW. Additionally, Fred's referral for assessment would have been recorded in the custody management record which would have been made available to Corrective Services NSW and travelled with Fred to Parklea Correctional Centre, thereby informing both MTC correctional officers and ultimately, St Vincents Correctional Health nursing staff of the circumstances in relation to Fred's suicidal comments and mental wellbeing. Furthermore, there would have been a permanent alert on the custody management record.

53 No police officer who gave evidence understood at the time that they could have added an alert in relation to Fred's mental health and suicidal comments to the police digital COPS system. They all thought that no alert could be added until the investigators had commenced an event and closed off the initial entry. It was Superintendent Stynes' evidence that any police officer could create an intelligence report in relation to Fred and add it to the system at any time.

54 Returning to the role of the custody manger, they typically would check the COPS system as part of their information gathering. As the Custody Management system and the COPS system do not cross populate, it is important this is done. Alerts stand as a permanent record accessible under the relevant individual's name. Given when

the individual officers heard Fred's comments, if anything had been added to the COPS system in a timely fashion, it may have come to the attention of one of the custody managers.

55 There is no suggestion in Fred's circumstances, that any of the three involved custody managers failed to adequately check the COPS system.

Fred is transferred to Parklea Correctional Centre.

56 Parklea Correctional Centre was a privately operated New South Wales prison as at September 2020. Parklea was run by MTC-Broadspectrum (MTC) pursuant to contractual arrangements with Corrective Services NSW (CSNSW). Nursing services at Parklea were provided by St Vincents Correctional Health (SVCH), again pursuant to contract. As referred to above, Fred was transferred into the care of CSNSW at Surry Hills late on the night of 2 September 2020. He was due to appear at Central Local Court on 3 September.

57 In a CSNSW New Inmate Lodgement and Special Instruction sheet completed at 10.45pm on 2 September, Fred's charges were noted and it was set out that Fred *guaranteed his own safety and wellbeing* whilst in the custody of Corrective Services NSW. Fred's conduct was described as *'compliant and polite'*.

58 The next morning, there was an incident in the CSNSW Surry Hills cells in which it was alleged that Fred spat at one correctional officer and bit another correctional officer. Charges were laid in relation to those allegations on 8 September 2020 and were first before Blacktown Local Court on 9 September 2020 during Fred's time at Parklea Correctional Centre (PCC). On 9 September the charges were adjourned to a date in October 2020.

59 A reception and accommodation checklist was completed at PCC at 11.35pm on 3 September. It contained content indicating Fred wanted to be in protection. He had fears for his safety (from others). There was also an indication on the checklist that Fred had no current thoughts of self-harm or suicide. On that same date, a shift manager wrote to the Governor of PCC indicating that Fred had made threats to kill a police officer and had also attacked CSNSW officers at Surry Hills Court cells causing his matter not to be heard in court due to fears he would attack an officer. As a result,

the shift manager requested that Fred be placed on a Protection Non-Association order for an initial 14 days for his personal safety and security.

60 An undated form signed by Fred and seeming to bear his handwriting, indicated that Fred wanted to be placed on Protection Non-Association. It is also to be noted that due to COVID-19, Fred, as with all other inmates, was to be isolated in cell for 14 days following his arrival at PCC.

61 A reception screening assessment (RSA) should have been undertaken by a nurse in compliance with policy within 24 hours of Fred's arrival at PCC. An RSA is required to be completed before cell placement can be determined. As no RSA had been completed, Fred was placed in the medical clinic until one could be completed.

62 In addition to completion of the RSA by nursing staff, an intake screening questionnaire (ISQ) must be completed by a correctional officer. Registered Nurse Tania Nguyen completed the RSA on 6 September 2020 at 10.04am. The evidence was that prior to that time Fred had not been co-operative with nursing staff who had previously sought to complete an RSA.

63 The CSNSW ISQ to be completed by an MTC officer bore the date '4/9/2020' alongside the words, "Date assessed," on p 1. However, in answer to question 3 it was indicated that the author had viewed the RSA and at the end of the document alongside Fred's signature was the date 6/9/2020. As elicited by Mr Harris for SVCH, answer 87 indicated the questionnaire was completed at 10.49am on 6 September. In written and oral evidence, Correctional Officer Rastrapal, who had conducted the questionnaire, accepted that it was completed on 6 September following the completion of the RSA.

64 The ISQ contained references to Fred's history of self-harm. However, the following questions and answers are relevant to the assessment Correctional Officer Rastrapal ultimately made.

> Question 51, "Do you have any specific concerns, fears for your safety while in custody or in the correctional centre?" The answer was, "Yes, I do. PRNA, Protection Non-Association pending."

Question 53, "Have you ever been treated or medicated for a mental health issue e.g. depression, anxiety, PTSD or schizophrenia?" Answer, "Yes, anxiety."

Question 58, "Have you ever hurt yourself in a stressful situation?" Answer, "No."

Question 61, "Have you ever seen a counsellor or psychologist or in the community?" Answer, "Yes, a psychologist."

Question 64, "Do you feel that there is hope for the future?" Answer, "Yes."

Question 66, "Do you have any current plans to self-harm or take your life?" Answer, "No."

Question 67, "Have you ever tried to take your own life or harm yourself in the past?" Answer, "No."

Question 71, "Would you like education/training to help you gain employment when released?" Answer, "Yes."

65 Correctional Officer Rastrapal indicated he took those answers at face value. He had no evidence or information suggesting the opposite was in fact the case, in relation to some of those answers. The ultimate outcome was that Correctional Officer Rastrapal entered no new alerts on the system in relation to Fred's mental health, wellbeing, or suicidal thoughts. The evidence at inquest was unclear at times but ultimately it was clarified that MTC alerts cross populated SVCH records. Thus, there were no alerts available to be brought to the attention of SVCH staff.

66 Registered Nurse Nguyen made her written statement in January 2026. When she gave oral evidence, she had no independent recollection of Fred. During her completion of Fred's RSA, RN Nguyen noted that Fred's indication of no mental health history was incongruent with previous Justice Health alerts of anxiety and depression. Fred presented to her as calm, cooperative, with normal speech, and coherent thinking. She did note that Fred felt paranoid at the time of the alleged assault on

police, however, Registered Nurse Nguyen noted there was no evidence of delusional ideation at the time of her assessment.

67 Fred denied any history of self-harm and Registered Nurse Nguyen noted during her assessment, there was no sign of Fred wanting to harm others. Specifically, a Kessler assessment indicated Fred was not currently experiencing significant levels of distress. Fred answered "No" to all the following questions: "Have you ever been treated for a mental health problem?", "Have you ever tried to hurt yourself?", "Have you ever tried to end your life?", "Has anyone in your family or close to you ever attempted to end their life or hurt themselves?", and "Is there anything causing you concern?"

68 When asked how he thought he would cope in prison, he indicated, "*Yeah, okay.*" Fred also indicated to Registered Nurse Nguyen he had no drug or alcohol issues and Registered Nurse Nguyen recorded all his physical medical observations as being within the normal range. In those circumstances, Registered Nurse Nguyen cleared Fred for normal cell placement. This meant Fred could be placed alone in segregation.

69 As noted, at this stage Fred had to be in isolation because of COVID-19 protocols. However, the clear evidence at inquest was that Fred wanted to be segregated from the general correctional centre population and MTC wanted Fred in segregation due to the nature of his charges regarding police and his asserted attack on CS NSW officers on 3 September 2020 at Surry Hills.

70 Fred was a "red dot" inmate, signifying he presented a danger to staff.

71 Whilst in segregation, Fred was seen everyday by nursing staff for welfare checks, and weekly by the Governor and the Head of safety and security.

72 Whilst in segregation from 6 September until his death on 25 September, Fred made no complaint about his wellbeing and was compliant to wing routine. Fred was spoken with by the Governor and Head of safety and security at approximately 10am on 24 September, as part of the regular segregation review. During this review, it was suggested to Fred he may be moved to the general prison population, as his behaviour had been compliant. After the review was completed, the Safety and security manager arranged for two intelligence officers to speak with Fred.

73 The intelligence officers spoke with Fred at about 1.30pm. Fred conveyed to them that he did not want to join the general prison population, referred to as, "main or mains", as he was concerned about other prisoners and recent media coverage suggesting he was a terrorist. Fred told these officers if he went to the mains he "*will climb on the roof or go on a hunger strike, as he believed he needed to remain in segregation due to the high media attention*". The officers then told Fred they did not think he would be moved due to the media coverage. The officers reported to the Safety and security manager that Fred was fine, his mood and demeanour were normal, and he was engaging well.

74 At about 2.58pm, Fred was served dinner. The correctional officer who placed the meal on the platform at the door reported that he asked Fred if he required anything else. Fred responded, "*No, I'm good*". At that time, Fred was sitting on his bed, his shirt was off, he was wearing his green shorts, shoes and socks, and he appeared to the officer to be fine. The cells were thereafter secured as there was a lock in muster. The rear yard cell door to Fred's cell was closed at about 3.08pm, and there was no conversation with him at that time. The officer responsible for the lock up recalls that Fred was quiet.

75 Fred was last seen alive on CCTV at 3.08pm on 24 September 2020. There were security checks performed in the segregation area during the evening of 24 September, but no interaction with Fred during those checks. No observations were performed on Fred during the night of 24 September. Observations were not routinely made on inmates in their cells during the night. Observation orders are made only when an inmate has been identified as at risk of self-harm or suicide. Because neither the health problem notification form nor the ISQ had identified Fred as being at risk of self-harm or suicide, he was not subject to any observation regime. There was no CCTV inside the cells in the segregation unit at the time of Fred's death. Fred's cell door was checked by correctional officers during the course of the evening, but he was not the subject of any direct observation on the night he died.

76 At approximately 8.16am on the morning of 25 September 2020, CCTV captured Correctional Officer Chapagain opening the outer door of Fred's cell and immediately thereafter using his radio. Correctional Officer Marwaha joined Officer Chapagain. They both observed Fred foaming at the mouth, unresponsive with eyes open and hanging by his neck from a green sheet tied to the ventilation slats within the cell. Whilst still outside the cell, Officer Chapagain used his Hoffman knife to cut the

bedsheet while holding Fred. He could not maintain the weight, and Fred fell to the ground, hitting his body and head on the cell floor.

77 A CERT 1 emergency call was broadcast via radio at approximately 8.20am alerting all available staff. CPR was commenced promptly by nursing and correctional staff. Nursing staff described Fred as pale or grey in colour, pulseless and unresponsive. Blood was observed from the left ear canal. Fred's jaw was tightly clenched, preventing insertion of airway adjuncts. Additional nursing staff attended, together with medical equipment, including oxygen, a bag mask ventilation, intravenous access equipment, fluids, adrenaline, and defibrillator monitoring equipment. These were all utilised during the ongoing resuscitation attempts.

78 Dr Michael Novy, a specialist emergency physician employed by SVCH, arrived at approximately 8.25am and assumed control of the resuscitation. CPR continued for approximately 40 minutes in total, including ongoing treatment following the arrival of NSW Ambulance paramedics. Despite extensive resuscitation efforts, there was no return of spontaneous circulation, no shockable rhythm, and no signs of life. Death was declared at 9.01am. The resuscitation effort was undertaken competently. Under the lead of Dr Michael Novy, the efforts were of a high standard.

79 As pointed out, the hanging point used by Fred was at the metal vents located directly above the gate cell door. The vents comprised of four horizontal vent panels and two thin vertical metal pieces. A green sheet had been tied between the third and fourth horizontal panels using the thin vertical metal piece directly under the roof.

80 When Officers Marwaha and Chapagain observed Fred in his cell, they discovered the padlock on the cell door to be blocked with what was thought to be plastic so that the padlock could not be opened by key. Correctional Officer Marwaha ran to the rear of the cell and opened the rear cell door. Correctional Officer Chapagain followed not far behind him. The need to run to the rear door delayed the commencement of resuscitation efforts by approximately 45 seconds to a minute.

81 In relation to cutting Fred's ligature, in oral evidence Correctional Officer Chapagain said he thought he had lowered Fred to the floor, however, in his witness report of 25 September 2020, he set out that Fred's bodyweight was pulling him towards the cell as it was getting heavier; "I couldn't hang onto it any further and had to let go". Without

any criticism at all of Correctional Officer Chapagain, I am satisfied that when the ligature was cut, Fred's body fell heavily to the floor.

82 Having set out relevant facts and circumstances, it is now convenient to consider the issues as identified in the issues list distributed to the parties. I will commence by considering issues 2 and 4 together.

Issues 2 and 4

83 Issue 2 requires an examination of the adequacy of the manner in which Fred's stated intention to end his life during the course of his interactions with NSW Police on 2 September 2020 was documented and communicated, and issue 4 requires examination of whether Fred's mental health was adequately identified and assessed by NSW Police whilst in police custody in September 2020 and whether they adequately shared the information they had in relation to Fred's mental state to MTC-Broadspectrum and St Vincent's Correctional Health and whether further measures or processes should be put in place.

84 As set out above, there was a failure of various police officers to advise the custody manager of Fred's stated intention to end his own life or their concerns as to the state of Fred's mental health. Whilst Fred's comments about ending his own life were adequately documented by junior police officers, the failure to advise the custody manager arose to a significant degree from systemic issues.

85 As at the time of Fred's arrest, the only police officers required by policy to advise the custody manager of suicidal comments were arresting and escorting police and any police officer in the role of custody assist.

86 These responsibilities were set out in two documents; *the charge room and custody management standard operating procedures* and *the custody chapter of the NSW Police handbook* as it applied at the time of Fred's arrest.

87 As at that time, a police officer in the role of custody assist had a responsibility to immediately report any issues to the custody manager. Arresting and escorting police were responsible for the care, control and safety of persons in custody until the person was formally handed over to the custody manager or another officer.

88 Arresting and escorting police had to complete an electronic field arrest lodgement on the custody management system and submit it to the custody manager. The handover included the physical transfer of custody and a verbal handover where information relevant to the person in custody's safe management, such as their physical and mental condition and drug and/or alcohol use, was to be clearly communicated to the custody manager. In Fred's circumstance, there was no suggestion that his statements as to death by cop, suicidal ideation, or thoughts of self-harm were said to arresting or escorting police.

89 Constable Kirk was in the role of custody assist during a portion of the time Fred was in custody. Constables Dut and Maya took property back to the station but were not arresting or escorting police as set out in the policy.

90 In the *Charge room and custody management standard operating procedures*, there was a section headed "M*ental health and self-harm*." It was noted therein "*there are some obvious warning signs for potential suicide. These might include direct statements of intent while others can be more subtle.*" The signs listed included *despairing or suicidal statements*. It was further noted:

> "*The custody manager must be updated with instances of actual and/or threatened self-harm and custody warnings should also be created. In the event of actual self-harm and/or the person in custody being transported for assessment under the Mental Health Act, a COPS event with appropriate warning needs to be created and the custody management system updated.*"

91 The Charge room custody management standard operating proecedures document was supplemented by the Custody chapter in the NSW Police Handbook which was applicable to all NSW police officers. I extract the following from that document as it applied in 2020:

> "*These guidelines focus on people who are under arrest at a police station, however you are accountable for your duty of care towards people under arrest and others in your custody at any time. Of prime importance is maintaining the safety and wellbeing of people in your custody and ensuring that their legal rights are protected.*"

92 Under the heading "arresting and escorting officer":

> "*To assist the assessment of detained people, check COPS for information such as warnings, and tell the custody manager or custody assistant if you are aware that a person has suicidal thoughts, a history of psychiatric illness, a history of suicidal behaviour or experienced a significance emotional loss recently.*"

93 I note again, in Fred's instance, there is no evidence that any of that background was available to arresting or escorting officers. In relation to the custody manager, the handbook noted;

> "*The initial assessment is vital to identify any risk, including whether the detainee has any potential for self-harm or has an illness, injury or condition, and/or requires medical assistance. The person must be assessed in a comprehensive manner before allowing them to be interviewed or further involved in the investigation.*"

94 Again, in relation to arresting/escorting officers,

> "*tell the custody manager or custody assist of any warnings particularly those about self-harm on the computer system. Search the National Names Index if appropriate. Remember to check each CNI if the person has more than one and arrange to link them. Custody manager assist, conduct your own COPS check for warnings. If the prisoner is brought from a gaol, you are responsible for the inquiry.*"

95 Those passages highlight the importance of all NSW police officers focusing upon the safety of inmates, or persons in custody, in regard to any potential for self-harm. However, as can be seen, they also focus upon allocating responsibility to specific officers limited to arresting or escorting officers and custody assists, in terms of the flow of information to the custody manager.

96 Whilst it might be thought that even the most basic understanding of the Custody chapter would have resulted in at least one of the police officers involved with Fred on 1 and 2 September, ensuring information regarding Fred's suicidal thoughts and comments and perceived mental health problems were relayed to the custody

manager, the evidence was that it was thought that the information would have been relayed by either one Detective Senior Constable who has since left the New South Wales Police Force, or a Deputy Chief Inspector who was overseas at the time of the inquest.

97 Leaving to one side what Sergeant Plane thought in terms of his expectation of any police officer who had heard the comments attributed to Fred, what common sense might suggest and what would seem as sensible flowing from the police handbook and the relevant standard operating procedures, the written policy material did not in terms specifically require any officer other than the arresting or escorting police and the officer in the role of custody assist to inform the custody manager of what they had heard and/or observed.

98 In those circumstances, the inquest was not adjourned to attempt to take evidence from the retired Detective Senior Constable or the overseas Chief Inspector as the fundamental failure was identified as systemic. In that regard it was accepted in the evidence and specifically by Superintendent Stynes, that the requirement to report the matter to the custody manager applying only to arresting and escorting police, and the custody assist officer was a significant and important policy gap.

99 I indicate again that there was no evidence at inquest of Fred expressing any suicidal comments to arresting or escorting police or of any arresting or escorting police thinking Fred showed signs of mental illness despite the nature of the offences Fred had allegedly committed. Officers Kaya and Dut were not escorting officers as their role had been limited to conveying property to Day Street Police Station. It was only police officer Kirk who, acting in the role of custody assist, had a specified responsibility in the policy documentation to inform the custody manager.

100 The evidence was that at the time of Fred's arrest, a junior officer would or could be told upon arrival at work on any given day, that they would be in the role of custody assist for their shift despite not having had any specific training in the role.

101 That situation has now changed, as Superintendent Stynes set out in his oral evidence, whereby officers must now do online custody assist training before acting in that role. Prior to that requirement being put in place, there had only been general training at the academy in relation to the custody chapter in the handbook.

102 Constable Kirk, now Senior Constable Kirk, impressed me as an honest witness and a committed police officer. This event occurred almost six years ago. He made a mistake in circumstances where he had not been sufficiently trained for the role he was required to undertake. It was clear that Senior Constable Kirk has both accepted and appropriately reflected upon his error.

103 Officers Dut and Kaya had no specific obligation to directly inform the custody manager of what they heard. In Officer Dut's case, it was clear to him the custody assist, Constable Kirk, had heard similar comments to those he had heard. Constable Kaya passed on the information relayed to him. Similarly, the undercover operatives passed on information provided to them. As I have said above, everyone thought the more senior investigating police would do something in relation to the relevant information. That is, in some instances, it was thought they may suggest Fred have his mental health assessed whilst in other instances, they thought the more senior officers involved in the investigation would advise the custody manager.

104 The first systemic failing lay in a failure to adequately train officers for the role of custody assist. It should be noted there was evidence from all officers who were asked that they could only retain portions of their academy training content, and Senior Constable Kirk, as he was when he gave evidence, pointed out that there was no time during shifts to study standard operating procedures and the handbook. I also note the evidence that custody managers are now required to do annual refresher training relevant to their role, and it is without dispute there has been much corporate energy put into better help police officers deal with the wellbeing of persons in custody who may be at risk of self-harm.

105 The second system failure lay in the gap in limiting the category of police officers required by policy to escalate self-harm comments to the custody manager. This second failing led to Counsel Assisting suggesting a recommendation be made, the spirit of which was accepted by Superintendent Stynes, and which has been supported by the Commissioner of Police in slightly altered terms to that originally suggested. I will make a recommendation in those altered terms.

106 As a result of the identified failings, I find that Fred's stated intention to end his life was documented adequately by the individual officers but wholly inadequately communicated to the custody manager. As a result, Fred's stated intention to end his own life was not conveyed to CSNSW, MTC-Broadspectrum or SVCH.

Issues 3 and 5

107 Issue 3 required an examination as to whether it was known to MTC-Broadspectrum or St Vincent's Correctional Health that Fred's intention on 2 September 2020 was to die and whether knowledge of that matter would and/or should have altered his management whilst at Parklea Correctional Centre. Issue 5 required an examination of whether Fred was appropriately assessed prior to being placed in segregation and whether it was appropriate to have Fred placed in segregation based on the available information in relation to Fred's mental health.

108 From what has been set out above, it is clear in relation to issue 3 that on the evidence at inquest, neither MTC nor SVCH were directly advised by means of the usual handover documents that Fred's intention on 02/09/2020 was to die.

109 The more difficult question is whether knowledge of that matter would or should have altered Fred's management whilst at PCC. In this regard, the Court heard valuable evidence from Registered Nurse Julie Dyer who was the Nurse Unit Manager at PCC at the time of Fred's death and later occupied the role of nurse manager. Registered Nurse Dyer is no longer with SVCH and gave evidence as a factual witness rather than as an institutional witness. She has, however, an extensive acquaintance with the policies and procedures that govern the management of inmates at PCC. She was in impressive witness.

110 Registered Nurse Dyer's evidence was that if it had been known to SVCH that Fred had told police he intended to hang himself in prison and that his conduct on 1 and 2 September had been an attempt at suicide by cop, the response would have been different in the following ways.

111 Firstly, a mandatory notification form would have been completed by SVCH staff recording Fred's self-harm risk. That notification would have led to Fred being placed on what is referred to as a RIT but in fact means being under the review of a Risk Intervention Team. Additionally, a mental health nurse would have been assigned to review Fred, and the mental health nurse would have attended on Fred on the same day as being advised of the self-harm threat. Assessment by a doctor would have followed if deemed necessary by the mental health nurse.

112 It is of significance that Registered Nurse Dyer indicated the denials and reassurances offered by Fred during the RSA and the ISQ and during his segregation reviews, would have been treated with greater scepticism and would not have been accepted at face value. For example, the Kessler 10 score of 10 out of 50 which Registered Nurse Dyer regarded as suspect with the benefit of hindsight, would have been the subject of further interrogation. Fred's initial placement in the main clinic would in all likelihood have been for the purpose of monitoring him possibly by a multidisciplinary team in the context of the disclosures of his attempt to commit suicide by cop, and his indication that he would hang himself in prison.

113 Ms Lawlor the Head of safety and security at PCC, similarly accepted that had she been aware of the matters Fred had told police, his area of placement would have been different. She accepted that he would have in all likelihood been placed in the clinic where camera cells are available.

114 Registered Nurse Nguyen, the nurse who completed Fred's RSA gave evidence to similar effect. Had she been aware that Fred had told police he intended to hang himself in gaol, she would have contacted the clinic immediately, arranged for a mental health nurse to attend and conducted a more rigorous assessment, interrogating Fred's denials and questioning him in different ways for a deeper understanding. She would have recorded self-harm risk on the health problem notification form (HPNF) and she would have expected Fred to be placed on a RIT.

115 Correctional Officer Rastrapal who completed the ISQ also gave evidence to the effect that had he had access to information that Fred had told police regarding his intentions to hang himself, he would have completed a mandatory notification form and would if necessary, have created a self-harm alert in the digital system.

116 In accepting the evidence of those witnesses, Lawlor, Nguyen, Rastrapal and Dyer, I have no doubt that if Fred's self-harm thoughts and aims had been relayed at handover to CSNSW and consequently to MTC Broadspectrum and SVCH, that Fred would have been placed under the care of the risk intervention team for assessment of his level of risk to himself. Additionally, he would have been assessed by a mental health nurse and/or monitored by a multidisciplinary team. However, it is simply not possible to determine what impact that alternative management of Fred would have had upon him or upon his ultimate actions. In the three weeks he was at PCC following his arrest, Fred gave no sign to any nurse or correctional officer of any intention to harm himself.

As set out above he was seen daily by nurses and weekly by the Governor and Security Manager, along with daily interactions with correctional officers. It simply cannot be known how long Fred may have remained in the main clinic under camera supervision.

117 What can be affirmatively stated, is that an opportunity to more fully understand what was impacting on Fred's mental wellbeing and risk of self-harm was lost. In relation to Issue 5, the foregoing makes plain that no criticism can be made of the decision to place Fred in segregation on the information known at the time the decision was made. As I have said, Fred wished to remain in segregation and was strongly opposed to being placed in the general prison population.

Ancillary Issues

118 Craig Mason, Executive Director of Strategy, Contracts and Commissioning for CSNSW gave evidence addressing the steps taken to reduce ligature risks at PCC. The louvered vent which Fred used as a hanging point has since been covered with a metal plate and mesh, reducing the ligature risk it presented. Further, the grill door to Fred's cell along with the grill doors in most, if not all CSNSW Correctional Centres have been removed, leaving only the single solid outer door. The removal of the grill has served two purposes. It has reduced the ligature risk within the cell and it has eliminated the opportunity for inmates to tamper with the padlocks, as had occurred in Fred's case.

119 Mr Mason also gave evidence that an independent handover review body has been tasked with reviewing PCC to identify any remediation work required, prior to the centre being returned to the management of CSNSW on October 1, 2026.

Cause of death, formal findings and Recommendation

120 I now turn to the formal findings.

121 A post-mortem examination of Fred was conducted on 30 September 2020 by Dr Irvine, Forensic Pathologist. Dr Irvine concluded that the cause of death was hanging. There were no suspicious or inconsistent findings on post-mortem examination.

122 The skull fractures identified on radiology were peri-mortem in origin and are consistent with Fred's body having fallen to the cell floor when he was cut down. There was no significant natural disease.

123 Fred died between 3.08pm on 24 September 2020 and 8.16am on 25 September 2020. He died at Parklea Correctional Centre, Parklea, NSW. The manner of Fred's death was deliberately self-inflicted.

124 I have already referred to the agreed position in relation to a recommendation to the Commissioner of NSW Police.

125 The recommendation that I make is

> That the Commissioner of NSW Police amend the NSW Police Force Handbook chapter titled, "custody," and the charge room and custody management standard operating procedures to impose an obligation on any officer who comes to learn, whether through their own observation or through information passed to them by a colleague, of anything that indicates that a person in police custody is at increased risk of self-harm or suicide for example, where they make statements indicating an intent to self-harm, either to communicate that information to the custody manager themselves or to satisfy themselves that it has been so communicated.

Closing comments

126 On behalf of the Coroners Court of New South Wales, I offer my deepest sympathies to Tanise and the family and friends of Fred for their loss. In doing this I would like to thank Tanise for her involvement in the coronial process, including attendance throughout the inquest, together with other family members.

127 I would like to also thank the officer in charge for his dedicated work in the coronial investigation and preparation of the brief of evidence.

128 I thank all the representatives for the manner in which they conducted the inquest. It is helpful for families when inquests are conducted with due and appropriate consideration and respect for the deceased and their family.

129 Finally, I express my deep gratitude to the assisting team. This was one of two inquests that ran partly together and partly consecutively. The team bore a very large burden in bringing that into effect and their work was of great assistance.

130 I close this inquest

Judge David O'Neil

Deputy State Coroner

Coroner's Court of New South Wales

10 July 2026