CORONERS COURT OF
NEW SOUTH WALES 44-46 Parramatta Road GLEBE

Jurisdiction:	Coronial
Name of Deceased:	Craig Anthony BEHR
File number:	354/2009
Hearing dates:	24/08/09, 26/08/09, 27/08/09, 28/08/09, 31/08/09, 01/09/09, 02/09/09, 03/09/09, 04/09/09, 07/09/09, 08/09/09, 09/09/09, 10/09/09, 11/09/09, 14/09/09, 15/09/09, 16/09/09, 17/09/09, 13/10/09, 15/10/09, 09/08/10, 10/08/10
Date of Decision:	14 December 2010
Coroner:	M.MacPherson
Representation:	Chris Lonergan, Counsel Assisting instructed by Gareth Lewis of the Legal Representation Office; Mr Farid Assaf and Mr Brett Shields of Counsel instructed by Henry Davis York for and on behalf of the family of Craig Anthony Behr; R P. Greenhill SC instructed by W. G. McNally Jones Staff Solicitors for Correctional Officers Martin and Lloyd; Patrick Saidi of Counsel instructed by the Crown Solicitor's Office for the Commissioner of Corrective Services NSW; Stephen C. Russell instructed by Noel F. Bracks for Correctional

Officers David Ulph, Apelu Too and Keith Smith; Mr G. Singh of Justice Health to 31 August 2009 and thence Ms L. Boyd of Counsel instructed by Gild Insurance Litigation Pty Limited as and from 31 August 2009; Mr R. Massey of Counsel instructed by Archibold Legal Solutions for Inmate Michael Heatley

Reasons for Decision

Introduction

1 At about 10.30am on Saturday 27 March 2004, ***Craig Anthony Behr***, who was then in the lawful custody of *Corrective Services NSW*, was moved into cell 20 of 13 Wing Long Bay Hospital Area 2 ("LBHA2") then occupied by another inmate, Michael Heatley. On arrival at LBHA2 inmate Heatley had been detained on a *"one-out"* basis. *"One-out"* detention meant that such an inmate was to be detained alone in a (separate) cell. At 12.39pm that same day a Correctional Officer answered a *"knock up"* call from inmate Johannes Schmidt who was in the adjoining cell to cell 20 (cell 21), inmate Schmidt having attempted to contact Correctional Officers via the *"knock up"* emergency call system for approximately 20 minutes beforehand. As a consequence of that "*knock up"* call eventually being answered, Correctional Officers attended cell 20 and observed inmate Heatley standing in front of the body of Craig Behr that was on the floor of (cell 20) displaying no visible signs of life.

2 Inmate Schmidt provided evidence in statement form to the Inquest in which he stated that he heard "*noises*" coming from cell 20 from about 12.15pm that day which caused him to use the cell "*knock up"* system. Inmate Schmidt believed the first noise he heard sounded like a body hitting the floor and that he then heard further sounds of banging coming from cell 20. On hearing these noises, he started pressing the emergency alarm button "*knock up"* from about 12.20pm.

3 As of Saturday 27 March 2004 Craig Behr was serving a sentence of full-time custody of seven (7) years and ten (10) months for *aggravated break and enter and commit a serious offence*. He was received into custody on 4 October 2001 for this offence and his earliest date for release was to be 2 August 2009.

4 As a result of the death of Craig Behr, inmate Heatley ultimately pleaded guilty to the charge of manslaughter of Craig Behr. On 21 November 2006 he was sentenced in the Supreme Court of New South Wales to a term of imprisonment comprising of a non-parole period of eight (8) years and a balance of term of six (6) years. The sentence was

to commence on 27 March 2008 and the non-parole period expires on 16 March 2016 with the balance of the term to expire on 26 March 2022[1].

5 To continue with this brief introduction of the facts, I note that just three (3) days before Craig Behr died, on the afternoon of Wednesday 24 March 2009, a Forensic Psychologist in the employ of *Corrective Services NSW*, Ms Danielle Matsuo, interviewed inmate Michael Heatley at the request of Senior Correctional officer, Assistant Superintendent Bernard Martin. The evidence before me is that immediately after that interview with inmate Heatley Ms Matsuo prepared a memorandum pertaining to this interview. I will refer to that memorandum as well as her subsequent report in more detail later in these findings. But immediately upon the completion of the interview, Ms Matsuo very appropriately informed a First Class Correctional Officer in Wing 13 of LBHA2 that inmate Heatley was not a risk to himself but rather was a risk to others and that he was to be placed in the observation cell (being a "*one-out"* cell) until such time as the Area Manager (Assistant Superintendent Bernard Martin) dealt with her report that she was about to prepare. Indeed the evidence establishes that Ms Matsuo had attempted to contact Assistant Superintendent Martin that same afternoon (24 March 2004) but was unable to do so through no fault of either her or Assistant Superintendent Martin.

6 It was the next morning (Thursday 25 March 2004), at about 8.00am, that she was able to briefly confer with Assistant Superintendent Martin and also, shortly thereafter, with Deputy Governor Nigel Lloyd and brought to their attention her professional view as regards the potential risk that inmate Heatley posed to others. That professional assessment made of inmate Heatley (by Ms Matsuo) was never challenged when she was called to give evidence at the Inquest. It was that: -

> "… Mr Heatley's risk of harm to others is currently assessed as high. He indicated to me that if he were placed 2-out or were made to mix with other inmates in the yard that it was highly likely that he would hurt someone and stated that he had been experiencing homicidal urges for the past 18 months."[2]

[1] R v Heatley [2006] NSWSC 1199 – Exh "2", Vol 5, Tab [84]
[2] Exh 2, Vol 6, Tab [136]

7 In handing down his reasons for decision on sentencing inmate Heatley for the manslaughter of Craig Behr, his Honour Justice Whealey of the Supreme Court of New South Wales, having received certain evidence from, inter alia, a number of Correctional Officers as to why it was that Craig Behr was placed in cell 20 with inmate Heatley, in circumstances that his Honour described as being likely to be, and indeed proved to be extremely, dangerous for the deceased (Craig Behr), concluded:-

> "90…..I have said enough in this brief summary of the facts and evidence placed before me to indicate that I am satisfied that the placement of Mr Behr in the offender's [Heatley's] cell occurred as a consequence of **both systemic and individual failures on the part of some prison officers** to adhere to proper practices and procedures. Had those practices and procedures been followed, the prisoner (inmate Heatley] would have remained "one out" and Mr Behr would not have died. It is clear to me that there is a significant likelihood that one group or other of the witnesses who gave evidence before me has not told the truth or is deliberately holding back information. Where the real and ultimate responsibility lies, I shall not, for the reasons I have earlier given, determine."
>
> *(My emphasis added)*

8 Then importantly his Honour has next observed: -

> "91 …. An independent and free ranging Inquiry is called for to answer the questions that the family of the deceased and the public legitimately ask to be answered; to explain why it was that a fellow inmate was placed in the offender's cell in circumstances where he had made it only too plain that he was in the grip of homicidal urges. The overall protection of the community and the need for the efficient operation of the prison system call out for, and demand, such an independent inquiry. I would hope that this recommendation falls upon receptive ears, even though its consequences may be unpleasant for some individuals, and perhaps for the Department of Corrective Services itself, at least in the short term."[3]

9 With Justice Whealey's comments in mind, much of the evidence of the Inquest placed before me was called and tendered in an attempt to determine why it was that just (3) three days after Senior Correctional Officers were warned, in explicit and direct terms, by a fellow professional employee of *Corrective Services NSW* as to the potential risk posed to other inmates by inmate Heatley, Craig Behr was in fact placed in a cell with him and was then found dead less than two (2) hours later.

[3] Ibid, Vol 5, Tab [84]

Role of Coroner

10 My role as Coroner is to establish, if possible, the identity, the date of death, the place of death and the manner and cause of death. The formal finding is to be recorded at the Registry of Births, Deaths and Marriages.

11 A Coronial Inquest is essentially an Inquiry. It is not a criminal or civil trial in which two opposing parties engage in legal combat. It is not the role of the Coroner to attribute fault or make findings in relation to negligence or breach of duty of care.

12 Another important function of an inquest is the making of recommendations, which are necessary or desirable in relation to any matter connected with a death. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

A Death in Custody

13 Craig Behr's death occurred at a point of time that he was held in lawful custody at LBHA2 by *Corrective Services NSW*. It appears from the inmate profile documentation for Craig Behr[4] that he was taken into custody on or about 3 October 2001 and charged with the offence(s) earlier cited. He was sentenced on 28 August 2003 to 10 years and 6 months imprisonment with a non-parole period of 7 years and 10 months. He was transferred to LBHA2 on 25 February 2004 on a medical appointment.

14 As Craig Behr died whilst in lawful custody, an Inquest into his death is mandatory pursuant to ***ss.13A and 14B*** of the ***Coroners Act***, as then applying, and is to be heard by the State Coroner or a Deputy State Coroner.

15 On *1 January 2010* the ***Coroners Act 2009*** ("the 2009 Act") took effect, it being assented to on 19 June 2009. Pursuant to ***s.108*** of the 2009 Act, the ***Coroners Act 1980*** was repealed. ***Schedule 2*** to the 2009 Act provides for savings, transitional and other

[4] Vol 6, Tab [135]

provisions and, specifically, ***Cl.14*** thereof applies to, inter alia, *part completed Inquests*. For this purpose reference is made to ***Cl.14*** of ***Schedule 2*** which provides: -

> *"(1) Subject to this Part and the regulations, this Act applies in relation to any inquest or inquiry under the former Act that was pending or part completed immediately before the repeal day (a "current inquest or inquiry") in the same way as this Act applies to an inquest or inquiry that is commenced on or after the repeal day.*
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> *(2) Without limiting subclause (1), the provisions of this Act dealing with functions of or in relation to juries extend to any current inquest or inquiry that was being held before a jury (or was required to be held before a jury under section 18 of the former Act) immediately before the repeal day as if:*
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> > *(a) a direction for the use of the jury had been given by the State Coroner under section 48 of this Act, and*
> >
> > *(b) in the case where the coroner for the current inquest or inquiry is not the State Coroner-section 48 of this Act authorised the coroner to preside over the current inquest or inquiry with the jury.*
>
> *(3) For the purpose of facilitating the continuation and conclusion of a current inquest or inquiry, the coroner holding the inquest or inquiry may give such directions concerning the conduct of the inquest or inquiry as seem appropriate to the coroner in the circumstances."*

16 Therefore the 2009 Act now applies in relation to this Inquest, it being a *part completed Inquest* as at the repeal date. In the circumstances, and by reason of the completion of the evidence on Tuesday 10 August 2010 there is no requirement for any directions concerning the conduct and continuance of the Inquest pursuant to the 2009 Act.

A Critical Incident Investigation, The Coronial Investigation Process

17 The Officer-in-Charge, Sgt. Sydney Davis, was appointed to that position on 20 December 2007 and thereupon was responsible for the coronial investigation into the death of Craig Behr for the purposes of the Inquest[5]. Sgt. Davis provided two (2) statements to the Inquest[6]. Exhibit "2" before the Inquest consisted of the original brief of evidence, consisting firstly of five (5) volumes that was prepared for the purposes of

[5] Vol 6, Tab [147]
[6] Vol 1, Tab [3] and again Vol 6, Tab [147]

the proceedings ultimately heard before Justice Whealey in the Supreme Court concerning the plea of guilty of inmate Heatley to the manslaughter of Craig Behr[7]. Volume 6 was added to the original police brief and became part of exhibit "2", and contained further material pertaining to the investigation of the circumstances surrounding the death of Craig Behr.

18 Also in evidence before me were the investigation reports undertaken by *Corrective Services NSW* into the death of Craig Behr[8]. These reports were authored by investigators being employees of *Corrective Services NSW* and, in general terms, deal with the compliance, or otherwise, by certain identified Correctional Officers, most of whom were in fact called before this Inquest, with operational procedures of *Corrective Services NSW*. These investigation reports contained numerous attachments, the majority of which were ultimately placed in evidence before me. I will make further comment about the investigation undertaken by *Corrective Services NSW* into the death of Craig Behr later in these reasons.

Issues for Determination

19 In addition to making a formal finding as to the cause and manner of death of Craig Anthony Behr, the following were identified as the more significant issues that required consideration and determination and were, in essence identified by Counsel Assisting in opening on 24 August 2009: -

A. Was the opinion formed by the Forensic Psychologist Danielle Matsuo (Matsuo), following her consultation with inmate Heatley and her subsequent actions following her observations of him, reasonable and appropriate in the circumstances?

[7] Exh 2, Vol 1 to 5
[8] See Exhibit s"25" & "26"

B. Were the actions of Deputy Governor Nigel Lloyd reasonable and appropriate in the circumstances?

C. Were the actions of Assistant Superintendent Martin reasonable and appropriate in the circumstances?

D. Were the actions of Officers Too and Ulph reasonable and appropriate in the circumstances?

E. Did Officers Plumb and Smith carry out, to a sufficient degree, *or at all,* the inquiries and checks they say they did prior to the transfer of and leaving the deceased, Craig Behr in Cell 20 with inmate Heatley shortly before midday on Saturday 27 March 2004?

Formal Finding

Date, Place, Cause and Manner of death of Craig Anthony Behr

20 Dr Paul Botterill, Forensic Pathologist with the Institute of Forensic Medicine, Glebe, prepared a post mortem report for the purpose of this Inquest[9] and stated that the direct cause of death of Craig Behr was "*CONSISTENT WITH HEAD INJURY AND THAT HE DIED AT APPROPRIATELY 12:15 HOURS ON 27TH MARCH 2004"*. Dr Botterill also reported that the head injury, as he observed it, was less severe than most lethal head injuries[10]. He also stated that, in his view, the sequence of events, as best as he could determine it, were that following the head injury to Craig Behr, then impaired consciousness followed, then vomiting and inhalation of debris which in turn led to brain hypoxia and (ultimately) death. Dr Botterill also referred to the fact that there were negative findings from the toxicology results for drug and other poison[11].

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9 Vol 2, Tab [62]
10 See generally Exh "1"
11 Ibid p.2 of 11

Finding

21 I am satisfied the direct cause of death of Craig Anthony Behr was "*Consistent with HEAD INJURY such injury having been caused by Michael Allan Heatley beating and kicking Craig Anthony Behr in cell 20 at Long Bay Hospital, Area 2 Long Bay Correctional Complex at about 12:15 hours on 27 March 2004 who died shortly thereafter*"[12].

Further Issues for Determination

A. Was the opinion formed by the Forensic Psychologist Danielle Matsuo (Matsuo), following her consultation with inmate Heatley and her subsequent actions following her observations of him, reasonable and appropriate in the circumstances?

22 Danielle Matsuo of the Psychological Branch of *Corrective Services NSW* gave evidence before me on 27 August 2009[13]. Ms Matsuo adopted her statement provided to NSW Police dated 22 April 2004[14]. Ms Matsuo was questioned at length about her reports that she prepared on 24 March 2004 and the following day. Particularly she was questioned as to the notations that appeared on the various versions of those reports[15]. But Ms Matsuo (and I make this observation without any criticism of her) was unable to assist as to the various handwritten notations that subsequently appeared on the various copies of her report to Assistant Superintendent Bernard Martin[16], all of which were separately tendered. In any event, those who authored these handwritten notations were unable to assist me as to the purpose and timing of the various versions of Ms Matsuo's report (with the particular handwritten notations).

23 At this point I record the following question was put to Ms Matsuo who provided what I regard as critical evidence: -

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12 Vol 2, Tab [62] and remarks on sentencing Vol 5, Tab [84], paragraph 75
13 Transcript of 27/08/09, pp.2 to 75
14 Exh 2, Vol 1, Tab [58]
15 Refer Vol 6, Tabs [135], [136] & [137]
16 Ibid Tabs [135], [136] & 137]

"Q. In the scale of things as at 2004, March, had you had the experience of obtaining such graphic and explicit details from an inmate as regards his idealization and intent before you interviewed inmate Heatley?

A. ***At that time I probably hadn't interviewed someone who I believed was so genuine in what he was saying. I had had cause to interview inmates who were a threat to others but not to this extent."***[17]
(My emphasis added)

24 The submissions received to date on behalf of those parties who chose to provide same, do not challenge or otherwise take issue with Ms Matsuo's professional opinion to the effect that inmate Heatley was a high risk to other inmates. Indeed, even if there was such a submission critical of her opinion, I would reject same. In my view her professional opinion was cogent, truthful and tragically accurate. The reports that she provided to both Assistant Superintendent Martin and Deputy Governor Lloyd on Thursday 25 March 2004, two (2) days before Craig Behr died, made clear what the potential consequences would be should inmate Heatley not be appropriately managed by *Corrective Services NSW* – that is to say, kept separated from other inmates. The tragic accuracy of her predictions contained in her reports of 24
and 25 March 2004 is quite chilling.

"I interviewed Michael HEATLEY Min 256679 this afternoon at your request. Mr Heatley gave me a verbal agreement that he understood there were limits to the confidentially of our discussions.

Based on his self-report during the interview today and his documented history of violence towards others in this centre, Mr Heatley's risk of harm to others is currently assessed as high. **He indicated to me that if he were placed 2-out or were made to mix with other inmates in the yard that it was highly likely that he would hurt someone and stated that he had been experiencing homicidal urges for the past 18 months**. Whilst he did not express any concrete plan if released from the Observation cell, he describes a plan that he developed whilst at the SPC.

Mr Heatley stated in the past the violent/homicidal thoughts decreased and that he became more relaxed when he is isolated from others. I have spoken to Coleman (Mental Health Nurse) regarding Mr Heatley's current risk of self harm/suicide, which we agreed is low. Therefore I recommend for the good order of the institution, and primarily for the safety of staff and other inmates, that Mr Heatley be managed in the ICMU. **While I identify there may be a degree of manipulation in his actions, as placement in the ICMU is what he**

[17] Transcript of 27/08/09, pp19.47 to p.20

wants, his past behaviour (e.g. assault on another officer at the MMTC) indicates a capacity to follow through with his words without hesitation.

I submit this report for your information and action.

Signed

Danielle Matsuo".[18] (Emphasis added)

25 I further find that Ms Matsuo did seek to contact Assistant Superintendent Martin following her interview with inmate Heatley on the afternoon of 24 March 2004 and that she also told, at about this same time, Senior Correctional Officer Too of her concerns regarding inmate Heatley. To the extent it is necessary for me to state, and I do not understand there is any dispute about this, I also find that Ms Matsuo, on the morning of Thursday 25 August 2004 fully appraised Deputy Governor Lloyd, and indirectly Assistant Superintendent Martin who read her report in Lloyd's Office on the morning of 25 March 2004[19] of her view as to the potential risk that inmate Heatley posed to other inmates and that she specifically drew to the attention of both these Senior Correctional Officers to the need for inmate Heatley to be "*Locked in one-out"*.

26 In the circumstances the opinion and advice formed by Ms Matsuo as regards the risks posed by inmate Heatley to other inmates, were clearly appropriate as were her actions in bringing same to the attention of Senior Correctional Officers by the morning of Thursday 25 March 2004.

B. Were the actions of Deputy Governor Nigel Lloyd reasonable and appropriate in the circumstances?

C. Were the actions of Assistant Superintendent Bernard Martin reasonable and appropriate in the circumstances.

[18] Vol 1, Tab [58]

27 I propose to deal with these two (2) issues together. That is because it is clear that, as I have found, that both Deputy Governor Lloyd and Assistant Superintendent Martin were appraised by Danielle Matsuo as of the morning of Thursday 25 March 2004 of her professional view as to the high risk posed by inmate Heatley to other inmates. I am also mindful that Mr Greenhill SC appeared for both Deputy Governor Lloyd and Assistant Superintendent Martin and has provided written submissions on behalf of both Officers which I have carefully considered.

28 Assistant Superintendent Martin gave evidence before the Inquest over a number of days[20]. Also before the Inquest was his initial statement given to police in May 2004[21], as was Mr Martin's evidence given before the Supreme Court at the sentencing hearing of Michael Heatley on 1 November 2006[22]. Assistant Superintendent Martin was, at the relevant time, the permanent Case Manager for Wing 13 and also Chairperson of the Case Management Team. I find significant that Mr Martin acknowledged and accepted that his first dealing with inmate Heatley took place on 23 March 2004 when Correctional Officer Plumb reported to him that "*Heatley's spinning out …*"[23]. He was therefore on notice as of the morning of Thursday 25 March 2004 as to inmate Heatley's earlier behaviour. After he had seen Ms Matsuo briefly on the morning of Thursday 25 March, and following his apparent reading of her report, it was Assistant Superintendent Martin's evidence that he said to Deputy Governor Lloyd that he would "… *take this report into consideration when … doing the RIT on Heatley*".

29 What next occurred of relevance was that a RIT (Risk Intervention Team) meeting took place between Assistant Superintendent Martin and Justice Health Officer Colman O'Driscoll on that same day. Assistant Superintendent Martin gave evidence that at this RIT meeting with Mr O'Driscoll he agreed that a new Health Problem Notification Form ("HPNF") be produced altering the cell placement from "*green dot*" statics (i.e. must

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19 See generally Assistant Superintendent Martin's statement, Vol 1, Tab [39]

20 Transcript of 31/08/09, pp.3 to 83, Transcript 01/09/09, pp.3 to 52, Transcript 02/09/09, pp.3 to 85 and 15/10/09, pp.14 to 23 & 56

21 Vol 1, Tab [39]

22 Vol 5, Tab [85], pp.43 et seq

23 Ibid Vol 1, Tab [39], paragraph 14

have cell mate – two-out) to "*normal cell placement*" which he stated would allow Heatley to be "*one-out*"[24].

30 Assistant Superintendent Martin then confirmed that the RIT with respect to inmate Heatley was terminated and further confirmed that he then wrote on the bottom of Ms Matsuo's report "*Noted RIT terminated, 2-out terminated to be locked in landing cell one-out until moved from centre"*. He said he wrote this in the presence of Mr O'Driscoll[25]. This is the handwritten note that appears on the bottom of the (original) *Matsuo memorandum* to Assistant Superintendent Martin dated 24 March 2004[26].

31 Following the RIT meeting with Mr O'Driscoll, Mr Martin stated that he spoke with First Class Correctional Officer Too. In that conversation Assistant Superintendent Martin said he informed Officer Too that inmate Heatley's RIT was terminated, that his two-out cell placement had been terminated and that he was to be kept locked in "*one-out*" on the middle landing until he (inmate Heatley) could be moved out of 13 Wing. Assistant Superintendent Martin also indicated in his statement that he informed Officer Too to ensure that other bottom and middle landing Officers knew of those directions[27].

32 Assistant Superintendent Martin's involvement and overview of inmate Heatley ends with the following action. He says that he then collected inmate Heatley's mandatory notification form and stapled a new *section 6* [mandatory notification form] to the front of the form and that he placed it and Danielle Matsuo's <u>original</u> report (memorandum) in the "*case management*" tray for filing in Heatley's case (management) file. He then placed a *paper clip* on these documents holding them together making sure that Danielle Matsuo's report, with his notations on it, was on top[28]. On 26 March 2004 Assistant Superintendent Martin was Acting Area Manager and had no issues/contact with inmate Heatley. On Saturday 27 March 2004 (the date of death of Craig Behr) he was on a rostered day off.

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[24] Vol 1, Tab [39], paragraph 19 and also Tab [58]
[25] Vol 1, Tab [39], paragraph 20
[26] Vol 1, Tab [39] & Vol 6, Tab [135]
[27] Vol 1, Tab [39], paragraph 23
[28] Ibid at paragraph 23

33 I now come to consider the actions of Deputy Governor Nigel Lloyd. Deputy Governor Lloyd gave evidence before the Inquest over two (2) days[29]. He was, at relevant times, Deputy Governor of LBHA2. As at March 2004 he had held that position for approximately 2 years. Deputy Governor Lloyd provided police with a statement which forms part of exhibit "2"[30].

34 Deputy Governor Lloyd stated that the first time inmate Heatley came to his attention was on 25 March 2004 when Danielle Matsuo Forensic Psychologist with DCS, attended his office and provided him with a one (1) page report that she advised ought be given to Assistant Superintendent Martin for his review. Deputy Governor Lloyd said he told her that he would ensure Assistant Superintendent Martin would get her report[31].

35 Deputy Governor Lloyd said he made some notes on the copy for the attention of Mr Martin and, shortly thereafter, Assistant Superintendent Martin attended his office and he handed Ms Matsuo's report to him. Deputy Governor Lloyd said that Assistant Superintendent Martin read the report whilst in his office and he then said that Heatley was to be the subject of RIT determination later that day (25 March). According to Deputy Governor Lloyd, he told Assistant Superintendent Martin to ensure that he (Martin) take the information contained in Ms Matsuo's report into account and report back to her because of her concerns[32].

36 At this point I have noted that prior to getting Ms Matsuo to review inmate Heatley on 24 March 2004, Assistant Superintendent Martin informed her that he was "… *taking up an obs cell"*[33]. Further, and following Ms Matsuo interviewing inmate Heatley and reporting her views to Deputy Governor Lloyd, the latter has commented to her "*Isn't Heatley just being manipulative?"*[34].

37 The next contact Deputy Governor Lloyd had concerning inmate Heatley occurred on 27 March 2004 at approximately 1.00pm when he was informed that one of the inmates in

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[29] Transcript 03/09/09, pp.4 to 90 and 04/09/09, pp.2 to 51
[30] Vol 1, Tab [36]
[31] Vol 1, Tab [36], paragraph 5
[32] Vol 1, Tab [36], paragraph 6
[33] Vol 1, Tab [58], paragraph 7
[34] Vol 1, Tab [58], paragraph 13

13 Wing supposedly had a "*heart attack*" and that he was requested by Senior Assistant Superintendent Walsh to attend 13 Wing. Subsequently Deputy Governor Lloyd attended 13 Wing middle landing, went to Cell 20 and observed an inmate laying on the ground whom he could not identify. Deputy Governor Lloyd indicated that Mr Walsh said that he did not think it was a heart attack and that it could have been an assault[35].

38 Later that same day, at about 4.00pm, Mr Walsh attended Deputy Governor Lloyd's office and "*appraised me of the situation*"[36]. Deputy Governor Lloyd thereafter ceased duties at 4.15pm and returned the following morning (Sunday 28 March) to prepare a death in custody along with a "*Governor's Synopsis Form*"[37].

39 Significantly when Deputy Governor Lloyd gave evidence before me to the effect that Assistant Superintendent Martin had said to him that, as regards the RIT meeting, it had been completed[38]. He did not recall any reference being made by Assistant Superintendent Martin to him that he (Martin and O'Driscoll) had any disagreement with regard to the placement of inmate Heatley to the effect that inmate Heatley ought be "*lock-in, one-out*". In fact Deputy Governor Lloyd gave the following evidence on that issue which was "*I can't recall him saying that to me*"[39]. Further Deputy Governor Lloyd was asked: -

> *"Q. And would you expect that if there was a disagreement between your Area Manager [Martin] and Mr O'Driscoll about an inmate who had had an assessment of harm to others as registering high by a forensic psychologist, that such a matter of disagreement would be brought to you're attention?*
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> *A. It would be brought to probably my attention if the disagreement had an unresolved management plan for the inmate. There was no unresolved management placement for the inmate they all agreed"*[40].

40 It was Assistant Superintendent Martin's evidence that he informed Deputy Governor Lloyd of his concerns – that is to say disagreement with Colman O'Driscoll was brought to the attention of Deputy Governor Lloyd but confirmed that reference to such

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35 Vol 1, Tab [36], paragraphs 10 & 11
36 Vol 1, Tab [36], paragraph 12
37 Vol 1, Tab [36], paragraph 12
38 Transcript 03/09/09, p.16.4
39 Transcript 03/09/09, p.17.41
40 Transcript 03/09/09, p.18.43 et seq

disagreement, significant as it was, was not mentioned by him in his police statement provided in May 2004[41].

41 Mr Greenhill SC takes issue with submissions made by Counsel Assisting concerning Assistant Superintendent Martin's evidence, particularly as to what took place between Assistant Superintendent Martin and O'Driscoll as to so-called expressions of concern made by Assistant Superintendent Martin regarding the placement of inmate Heatley as a "*normal cell placement*". I note that in other respects Senior Counsel puts the proposition that where there is a difference between the evidence of Assistant Superintendent Martin and that of Justice Health Officer Colman O'Driscoll the former's evidence ought be preferred, indeed he says the totality of the O'Driscoll evidence ought be rejected.

42 I must say that whilst Mr O'Driscoll was not a helpful witness, I have more significant concerns with the evidence of Assistant Superintendent Martin. That difficulty with his evidence is twofold. The Assistant Superintendent's evidence is that he informed Deputy Governor Lloyd of his concerns as regards the disagreement he had with Colman O'Driscoll at the RIT meeting. The simple fact of the matter is that Deputy Governor Lloyd has stated he has no recollection of being informed of that disagreement by Assistant Superintendent Martin. Secondly, there was no reference to that alleged disagreement given in the statement that Assistant Superintendent Martin provided to NSW Police back in 2004[42], a fact Assistant Superintendent Martin was unable to explain. That there was strong disagreement at a RIT meeting I would have thought warranted some reference in the statement given to NSW Police two (2) months after the event. It is, in any event, absurd for Assistant Superintendent Martin to suggest that he required the "*approval*" of a rather junior Justice Health Officer to classify an inmate (Heatley) as "*lock-in, one-out*". I also note that the purpose of the RIT meeting, such as the RIT meeting of 25 March 2004, was to determine whether inmate Heatley was and remained a risk to himself not whether he was to be classified "*lock-in, one-out*".

43 In the circumstances and notwithstanding the strong submissions made on behalf of Assistant Superintendent Martin, to the extent that there are differences in the evidence

[41] Transcript 31/08/09, p.35, line 20 to 37

in the RIT meeting between Assistant Superintendent Martin and Justice Health Officer O'Driscoll I reject the evidence of Assistant Superintendent Martin. Specifically I reject Assistant Superintendent Martin's evidence that there was disagreement between he and Mr O'Driscoll at the RIT meeting.

44 As to the adequacy and appropriateness of the response by Assistant Superintendent Martin and Deputy Governor Lloyd to the specific warnings provided by the *Corrective Services NSW* Psychologist Danielle Matsuo, I have come to the conclusion that both these senior officers failed to acknowledge the force of Ms Matsuo's opinion and to thereafter take appropriate steps and actions for the safety of other inmates. Indeed they have essentially ignored the seriousness of that advice that they were given by the Department's own psychologist. I am mindful of the need to ensure that I do not, with all the benefit of hindsight, impose unrealistic standards on such officers when reviewing the actions of persons such as Assistant Superintendent Martin and Deputy Governor Lloyd. In this respect I fully appreciate that over their long experience within the Correctional system, they have to be properly alert to prisoners who seek to exaggerate events for their own benefit. One benefit for inmate Heatley might have been, for instance, to secure "*better accommodation"*. In this regard I note that it would seem that the first thought that has come into the minds of both Assistant Superintendent Martin and Deputy Governor Lloyd was the fact that inmate Heatley may have been manipulative – that is to say manipulating the circumstances to procure "*better accommodation"* in the form of a single "*one-out"* cell. However it is undeniable that the considered view of Danielle Matsuo took that possibility into account. Her report specifically refers to such considerations (of possible manipulative behaviour). Yet Assistant Superintendent Martin and Deputy Governor Lloyd have failed to act upon her advice. Simply to finalise the situation by leaving a bundle of papers on the top of a filing tray is, in no way, an adequate response to a dire warning of risk of harm with no subsequent follow-up in the two (2) days leading up to the death of Craig Behr. Further, and without abrogating Deputy Governor Lloyd's responsibility, Assistant Superintendent Martin should have himself instigated a regime/procedure so as to ensure that Ms Matsuo's concerns were addressed and implemented. There were no accountable steps put into place by Assistant Superintendent Martin to ensure these took

[42] Transcript 03/09/09, pp.17.41 & 18.43

place. Indeed as Counsel for Justice Health has observed in her submissions to me that there were numerous opportunities and methods available for Deputy Governor Lloyd and Assistant Superintendent Martin to have communicated to other *Corrective Services NSW* Officers that inmate Heatley had been assessed as posing a high risk of harm/danger to other inmates and was to be kept "*one-out"*, that is to be isolated from other inmates. As submitted by Counsel for Justice Health, those steps could have included utilising the case management files with specific notations, briefing officers at the daily parade, ensuring that there were whiteboard notifications, making specific entries on the wing and landing logs and the use of the telephone to call the Area Manager or the Case Manager to ensure that their directions were actioned immediately and were followed-up with appropriate paperwork. And finally utilising the muster book. All of these available steps could have ensured accountability was overseen.

45 Further, Deputy Governor Lloyd's remarks to Assistant Superintendent Martin on the morning of Thursday 25 March 2004 to ensure Ms Matsuo's advice is taken into account (at the RIT meeting) entirely misses the point, given for the purpose of the RIT meeting.

D. Were the actions of Officers Apelu Too and David Ulph reasonable and appropriate in the circumstances?

46 First Class Correctional Apelu Too provided a police statement[43] and also gave evidence before the Inquest[44]. It is the case that *Corrective Services NSW* Psychologist Danielle Matsuo advised Correctional Officer Too on Wednesday 24 March 2004 that inmate Heatley was not a risk to himself but a risk to others and, further, that the day after that occurred, on 25 March 2004, he was informed by Assistant Superintendent Martin that inmate Heatley was clear to go back to the middle landing of LBHA2 on normal placement and was to remain "*one-out"*.

47 I have considered the evidence given by Officer Too as well as the submissions made on his behalf. I have difficulty with accepting the entirety of his evidence. It seems to me that Correctional Officer Too was one of those Correctional Officers who provided evidence in a manner that was designed to protect his position. For instance in his

[43] Vol 1, Tab [34]

evidence he urged upon me that the reason why the appropriate entries were not made in the landing logs was that he was awaiting paperwork[45]. Ultimately Correctional Officer Too indicated that the transfer of inmate Heatley from the observation cell to the middle landing went ahead without the paperwork from Mr Martin[46]. He could not recall anything being written on the middle landing office whiteboard concerning the basis upon which inmate Heatley was to be detained. Nor could he remember whether any other Correctional Officers were made aware that inmate Heatley was to be kept locked in "*one-out*" as he was a risk to other inmates. Officer Too simply indicated he was aware that inmate Heatley was to be kept "… *locked in the cell*"[47]. I then asked Officer Too the following series of questions against the background that if inmate Heatley was to be "*normal cell placement*" why was it that three (3) Correctional Officers were to be with him at all times: -

> *"A. "I don't know, at that time sir, he was locked in there, and there is a normal procedure if someone is locked in there, they normally have 3 officers.*
>
> *Q. Why?*
>
> *A. It is in them, it is in the person it is in me.*
>
> *Q. Why do you have 3 officers, why not just one officer?*
>
> *A. It is a common procedure in the wing that we work in sir.*
>
> .
>
> .
>
> *Q. Why do you have 3 officers taking him for a shower, do you want me to, how about because he is dangerous, is that the reason you've got 3 officers?*
>
> *A. Yes."*[48]

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[44] Transcript 07/09/09, pp.2 to 74
[45] Transcript 07/09/09, p.6.8
[46] Ibid p.13.23
[47] Ibid p.33
[48] Transcript 07/09/09, p.70, line 35 et seq

48 Correctional Officer David Ulph gave evidence to the Inquest, firstly in the form of a statement given to NSW Police and dated 22 May 2004 as well as oral evidence to the Inquest on 7 and 8 September 2009[49]. The critical aspect of Correctional Officer Ulph's evidence was whether I can accept that he had written on the whiteboard of Wing 13 a warning, for want of a better description, to the effect that inmate Heatley was to be held "*one-out"*. As if to emphasise that point Correctional Officer Ulph told the Inquest that he recalls putting a big asterisk on that whiteboard[50]. Correctional Officer Ulph also indicated that it was quite possible whilst he recalls that he did write such a notation on the whiteboard, it may have been deleted[51].

49 When considering the evidence of both Correctional Officers Too and Ulph I have been left with the impression, as I have earlier mentioned with respect to the evidence of Officer Too, that both Officers gave their evidence in a very guarded and "*self-protecting"* manner. In the circumstances I simply am not in a position to accept that Correctional Officer Too treated inmate Heatley to be kept "*one-out"*[52] and that Correctional Ulph in fact wrote on the whiteboard anything to indicate that inmate Heatley was to be "*one-out"*.

50 Having said that I am of the view that whilst it may have been mentioned to them, and in particular Officer Too by Assistant Superintendent Martin on Thursday 25 March 2004, that inmate Heatley was to be kept "*one-out"*, that was the extent of the follow-up by Senior Correctional Officers (Martin and Lloyd). I state again the overview and follow-up of inmate Heatley, such need being obvious in the light of the opinion of the Psychologist Danielle Matsuo, simply evaporated as and from Thursday 25 March 2004.

E. Did Officers Plumb and Smith carry out, to a sufficient degree, or at all, the inquiries and checks they say they did prior to the transfer of and leaving the deceased, Craig Behr in Cell 20 with inmate Heatley shortly before midday on Saturday 27th March 2004?

[49] Vol 1, Tab [40] and Transcript of 07/09/09 and 08/09/09 at p.75 to 101 and thence p.1 to 61
[50] Transcript 07/09/09, p.91, line 36 to line 40
[51] Ibid p.92.36
[52] Transcript 07/09/09, p.70, line 35 et seq

51 Correctional Officer Smith provided evidence in the form of a police statement[53]. He also gave evidence before the Inquest on 9 and 10 September 2009[54].

52 In his evidence Officer Smith indicated that he did not know the basis for, nor the origin of, the direction(s) that inmate Heatley was to be locked in "*one-out*"[55].

53 Further Officer Smith indicated that it did not occur to him during the course of Saturday 27 March 2004 to find out why Heatley was in fact "*locked in*" and, specifically for this purpose, to ring the Area Manager of the day Mr Walsh[56]. Further he did not recall Officer Plumb ever telling him that he had in fact rung the Area Manager (Walsh) to find out[57]

54 Officer Smith agreed that there were occasions on 8 and 9 September 2009 that he had answered questions to the effect that he *did not recall* certain matters but otherwise asserts that there was nothing wrong with his memory[58].

55 Officer Smith confirmed that he and Officer Plumb did locate the Area Manager's log[59].

56 In answer to a question from me to the effect that if the landing log had had "*locked in one-out"*, whether this would have made any difference to the decision to move (Craig Behr in with inmate Heatley), Officer Smith has replied "*Absolutely, sir. Absolutely, Craig Behr would have been alive today"*[60]

57 Officer Smith also indicated that the HPNF for inmate Heatley was on the top (of the case file) when he accessed it on 27 March 2004[61].

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53 Vol 1, Tab [19]
54 Transcript 09/09/09 and 10/09/09, p.1 to 47, 55 to 72 and 2 to 35
55 Ibid, 09/09/09, p.10
56 Transcript 09/09/09, p.11
57 Ibid, p.12
58 Ibid, p.16 & 17
59 Ibid, p.18.5
60 Transcript 09/09/09, p.19.1 et seq
61 Ibid, p.22

58 Having been directed to the report of Danielle Matsuo as contained on the case management file and also having stated that he was aware who Danielle Matsuo was (being a Forensic Psychologist), he was then asked this question: -

> *"Q. Do you say that you never saw that report on that file this day?*
>
> *A. Yes, sir, I do.*
>
> .
>
> .
>
> .
>
> .
>
> *Q. Given that you never went any further in the file after you saw the words 'normal cell placement' on the health problem notification form, you did not turn your mind to a further search of the file, is that right?*
>
> *A. That's correct, sir".*[62]

59 I also note Officer Smith was aware (as was Officer Plumb) that inmate Heatley had in fact "*spun out"* four (4) days before Craig Behr was moved in with inmate Heatley, that is on 23 March and that he knew that he had come back to 13 Wing.

60 Officer Smith also believed, on being shown cell card 20 for the movement of Craig Behr to that cell on Saturday 27 March 2004, that it is in his handwriting[63].

61 It was also Officer Smith's evidence that he had no reason to believe that inmate Heatley should be "*one-out"* and the basis for that belief was because the health problem notification form stated "*normal cell placement".*[64]

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[62] Ibid, p.24 to 25
[63] Transcript 09/09/09, p.35
[64] Transcript 10/09/09, p.8 to 9

62 Officer Steven Plumb gave evidence by way of statement dated 7 April 2004[65] and also before the Inquest on 10 and 11 September 2009. As well Officer Plumb gave evidence at the sentencing hearing of inmate Heatley[66].

63 Officer Plumb confirmed it was his decision to put Craig Behr in with inmate Heatley[67].

64 He ultimately agreed that it was strange that no one from *Corrective Services NSW* had asked him to prepare an *Officer Report Form* concerning his involvement in the matter on this particular day following the death of Craig Behr[68]. Officer Plumb agreed that he did speak with Officer Smith after the event (the death of Craig Behr) whilst he was in Deputy Governor Lloyd's office that Saturday afternoon (27 March 2004). But he could not recall what he discussed with Officer Smith[69]. He also did not recall what it was he said (if anything) to Deputy Governor Lloyd about his own knowledge of how Craig Behr was placed in the cell with inmate Heatley to Deputy Governor Lloyd[70].

65 Officer Plumb said he could not recall telling Senior Assistant Superintendent Walsh, when he had phoned for the case management file to be brought to the Deputy Governor's Office of his involvement with Craig Behr and of placing Craig Behr in inmate Heatley's cell on the day in question. This lack of recall is of concern to me.

66 Notwithstanding the inability to recall events surrounding the placement of Craig Behr in cell 20, Officer Plumb nonetheless agreed with the proposition that the death of Craig Behr was not an insignificant event[71].

67 Further he stated (and this is also of significance) that he does not recall Governor Lloyd asking him any questions when he was Deputy Governor Lloyd's office on the afternoon of 27 March 2004 concerning his (Plumb's) involvement[72].

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[65] Exh "2", Vol 1, Tab [28]
[66] Vol 5, Tab [85], p.116 et seq
[67] Transcript 10/09/09, p.42.40
[68] Ibid, 43
[69] Transcript 10/09/09, p.47
[70] Ibid
[71] Ibid, p.53 to 54
[72] Ibid, p.54

68 Officer Plumb was also shown exhibit "13", being the original cell card for Cell 20, but could not provide any explanation as to the whiting out that appears on the cell card. He also indicated that he was aware that Correctional Officers are not allowed to alter documents in that manner. He further stated that (as a matter of procedure) if an officer makes a mistake/error on a document it is best practice to rule it out and initial same[73].

69 Officer Plumb also gave evidence that on the morning of 27 March 2004, and following an inquiry made of Officer Plumb by Officer Smith as to "*Why is Heatley on a lock up"*, he has indicated that he did not know the reason but that they would look through the paperwork in an attempt to find out. Then the following evidence was given: -

> *"Q. Do you tell his Honour on your oath you never turned your mind to the fact that one of the reasons might have been that he was assessed as being a potential risk to others?*
>
> *A. No I did not think at all."*[74]

70 As to the events of him accessing the case management file for inmate Heatley, Officer Plumb says he flicked through the few folios and was looking for anything that would indicate why it was that inmate Heatley was to be on "*lock in*". Specifically he said he saw no reference to any report of Danielle Matsuo[75].

71 Officer Plumb said that he did look in the Area Manager's log to see if he could find any information as to why Heatley was on "*lock in*". When shown the entry for 25 March 2004 in the Area Manager's log, Officer Plumb's evidence was, as he recalled it, there was nothing written as regards inmate Heatley's status of being "*one-out"*[76].

72 Officer Plumb confirmed that he had not talked with the Area Manager for Saturday 27 March 2004, being Walsh, because he had not seen him, nor had he talked to him as he

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[73] Ibid, p.57
[74] Transcript 10/09/09, p.65.10
[75] Ibid, p.68.45
[76] Ibid, p.72

was not in the Wing. However Officer Plumb says he did attempt to find him as he sent out a radio call to which there was no answer. The radio call was made by a Motorola (two way) that he had on his (Plumb's) belt. Officer Plumb also asserts that Mr Walsh should have a Motorola[77].

73 However Officer Plumb indicated that at no point of time prior to he and Officer Smith transferring Craig Behr into inmate Heatley's cell did he speak with Walsh[78].

74 Officer Plumb also identified the blue copy of the HPNF as being the actual document that he had access to (on Saturday 27 March 2004) referable to inmate Heatley[79]. But he did not have an explanation as to why there was a yellow copy of same on the case management file[80].

75 Officer Plumb's attention was drawn to exhibit "15" (the landing log for 13 Wing). He stated that he recalled having access to that log after they were called back to the Wing when inmate Heatley had attacked Craig Behr. He confirmed that at no point of time prior to that did he look at that log. Officer Plumb's explanation for not accessing same was that Officer Smith had come down and said it was locked up and also there was nothing written on the whiteboard or in his diary. He took his (Smith's) word for it[81]. Officer Plumb indicates that he did recall talking to Officer Ulph about the incident and being advised by him that inmate Heatley had been put in as a "*lock up*" and that he thinks that Officer Ulph said to him he wrote something on the whiteboard. However, and telling, Officer Plumb had told him that he had seen nothing written on the whiteboard[82].

76 In the circumstances I am left with the impression that again both these Officers (Smith and Plumb) have attempted to put the best possible gloss on their evidence to protect their positions. In the circumstances I cannot accept their evidence to the effect that they did make some attempt to find out why inmate Heatley was to be kept locked in "*one-out"*. Nor do I accept that Officer Plumb attempted to radio Senior Superintendent Peter

[77] Ibid, 74 and 75
[78] Transcript 10/09/09, p.76.7 et seq
[79] Ibid, p.77.42
[80] Ibid, p.77.46
[81] Transcript 11/09/09, pp.1 and 2

Walsh prior to moving Craig Behr into cell 20 just prior to the lunch down lock up on Saturday 27 March 2004.

77 With no entry being made in the relevant log[83] indicating the basis upon which inmate Heatley was to be locked in – that is to say no reference to "*one-out*", Officer Plumb has made the decision to place Craig Behr in cell 20 with inmate Heatley. The evidence of Officers Plumb and Smith is that Craig Behr was moved from Cell 27 into Cell 20 with inmate Heatley. Both officers allege that inmate Heatley and Craig Behr shared a cell sometime prior to 27 March 2004 without difficulty. Both officers were aware that inmate Heatley was, at the time, "locked in" but were unaware of the reason for that status. They assert that they made various enquiries to ascertain the reason but without success. They said in evidence they looked through the case management file and other places and found nothing of relevance. They also say they saw nothing (of relevance) on any whiteboard. Their evidence of undertaking a search to ascertain the reason for Heatley's "*locked in*" status is at best problematic.

78 Accordingly, and Officer Plumb has taken responsibility for this, absent being appraised of the reason for why inmate Heatley was "*lock in*", Craig Behr was moved into Cell 20 with inmate Heatley.

The Cell Call Activity System

79 This system, referred to as the "*knock up*" system, was the subject of certain evidence, both oral and documentary, at the Inquest[84].

80 It would seem from the available material that inmate Schmidt first activated the "*knock up*" call but in his cell (cell 21) at about 12.16pm (shown as 11.05.28). That call was apparently answered only at 12.39pm (shown as 11.28pm) at the gate house, that is say some 23 minutes after inmate Schmidt made his first call. Officer Parry would appear to have been the person who could have answered that call but for reasons that he gave in his evidence before the Inquest, he diverted/disconnected those calls emanating from cell

[82] Ibid, pp.12 to 13
[83] Exh "16"
[84] See Mr Ross Alfonzetti of transcript 16/09/09, pp.8 to 43

The reasons he gave for that action of disconnecting the calls I reject. Officer Parry (now retired) says that his practice was "*What happens when I get an inmate who constantly presses [the knock up button] and ties up the knock up system with no emergency is to answer, if possible, every 20 minutes or so and that way if there is any backlog of calls they can be answered*"[85].

81 In short I find that the explanations provided by (former) Officer Parry are not cogent and are otherwise unreliable. In the circumstances I find that he should have answered the "*knock up"* from cell 21 much earlier. It was ultimately answered (by Correctional Officer Kristy Turner) when she opened the call at 12.39pm. This delay bears some significance because that 23 minute delay after inmate Schmidt first made his call must be judged against the background of the evidence of Dr Botterill who says that death appeared to have occurred in a "*progressive manner*" – that is to say over some short period of time. Therefore it cannot be ruled out that had there been a more timely response to answering the "*knock up"* some resuscitation efforts could have been implemented and which could have been successful.

Summary

82 The lack of action, the lack of follow-up, the lack of seeking specific directions from superior officers on the day of the death of Craig Behr, all arose from the fact that insufficient regard was paid by Assistant Superintendent Martin and Deputy Governor Lloyd to the warning/advice given to them by Ms Matsuo on the morning of Thursday 25 March 2004 of the high risk of harm that inmate Heatley posed to other inmates.

83 As a consequence I am satisfied that <u>following</u> Ms Matsuo's presentation of her report to both Deputy Governor Lloyd and Assistant Superintendent Martin on 25 March 2004 there was a near total lack of appropriate action by various Correctional Officers, commencing with Deputy Governor Lloyd and Assistant Superintendent Martin of not ensuring/overseeing, in an appropriate manner, that Ms Matsuo's recommendations were actioned, recorded and acknowledged by all appropriate staff in 13 Wing. As a result the

[85] Vol 1, Tab [30], paragraph 15

duty to hold Craig Behr in custody under supervision in a safe and secure manner was breached.

Generally

84 These were the issues that were identified at the commencement of the Inquest as being those that required determination. As the evidence was presented at the Inquest certain additional issues arose that now require my comment and these largely centre upon events that took place following the discovery of the body of Craig Behr.

85 Firstly the case management file for inmate Heatley, that became an exhibit at the Inquest[86], being the original case management file, was in fact an incomplete version of a copy which was provided to NSW Police a few days following the death of Craig Behr, it being a complete copy version[87]. In short it appears that the original (exhibit "17") which was ultimately produced under subpoena to those assisting the Inquest had certain segments missing from it[88]. I am also satisfied that this case management file was closely scrutinized, firstly by Senior Assistant Superintendent Peter Walsh and on the afternoon and evening of 27 March 2004 and thence at a later point by the Manager Inmate Classification, *Corrective Services NSW*, Domenic Pezzano. As the evidence presently stands I am not in any position to make a finding as to who was responsible for what is in effect the disappearance of certain segments from the case management file of inmate Heatley.

86 There is another issue that has concerned me and that is the cell cards from Wing 13 and particularly cell card 20. This has been the subject of submissions by Counsel Assisting. I accept that the whiting out entries on cell 20 are a cause of great concern. As the evidence presently stands, I am again not in a position to find who caused the "*whiting out*" or why it was difficult for *Corrective Services NSW* to locate that particular cell card at first instance. I am presently satisfied that the entries on cell card 20 are both erroneous and I strongly suspect that there has been an attempt made, after the body of Craig Behr was found, to sanitise/obliterate certain entries on cell card 20 by a

[86] Exhibit "17"
[87] See Vol 4, Tab [69]
[88] Viz: The 14 day report (original)

Correctional Officer in an attempt to conceal, albeit in a clumsy manner, entries on this particular cell card that were made after the discovery of Craig Behr's body. But as the evidence stands, I am not in a position to say who caused the "*whiting out*".

87 Immediately upon the body of Craig Behr being discovered it appears that Senior Correctional Officers took possession of relevant documentation and I am left in the position where some of it is now missing and some of it has been the subject of attempted alterations. I again repeat I am not in a position to say who is responsible but it leads me to make the attached recommendation, the effect of which is that immediately upon a death in custody being notified to police, *Corrective Services NSW* are to release control of all relevant documentation to the relevant NSW Police Critical Incident Teams such that the Critical Incident Team takes possession for the purposes of examination and review all relevant documentation from the commencement of its investigation and retains same until the Coroner directs otherwise.

88 This also leads me to make some observations regarding the investigations undertaken in the death of Craig Behr by *Corrective Services NSW*. The two (2) investigation reports by *Corrective Services NSW*, undertaken by the State Investigative Group, became exhibits "25" and "26" at the Inquest. On any view of it these are detailed investigations undertaken by the Departmental Investigators. There is certainly a common thread running through the investigations to determine how it was that Craig Behr was placed in a cell with inmate Heatley on 27 March 2004. But I further observe that the thrust of the reports was concerned with issues of compliance or otherwise by Correctional Officers with standard procedures and whether as a result of such findings recommendations for disciplinary action ought be instigated. I do not propose to make any further comment to these internal investigations.

Formal Finding

I FIND THAT CRAIG ANTHONY BEHR DIED ON SATURDAY 27 MARCH 2004 AT ABOUT 12.15PM IN CELL 20 AT LONG BAY HOSPITAL AREA 2, LONG BAY CORRECTIONAL CENTRE THE DIRECT CAUSE OF DEATH BEING CONSISTENT WITH HEAD INJURY OCCASIONED BY INMATE MICHAEL HEATLEY.

89 To the family of Craig Behr, and in particular his mother who sat in Court throughout this Inquest, I offer my sincere sympathy and I do trust that this Inquest will in some way assist her and her family to understand the circumstances of Craig's death.

90 Section 82 Recommendation

To the Minister for Corrective Services and to the Commissioner Corrective Services New South Wales

I recommend that immediately upon a death in custody being notified to police, *Corrective Services NSW* are to release control of all relevant documentation to the relevant NSW Police Critical Incident Teams such that the Critical Incident Team takes possession for the purposes of examination and review all relevant documentation from the commencement of its investigation and retains same until the Coroner directs otherwise.

M.MacPherson

Deputy State Coroner

14 December 2010