



## **NEW SOUTH WALES STATE CORONER**

**Name of Deceased:** Terry Griffiths

**File Number:** 3499/09

**Hearing Dates:** 4 - 5 & 12 August 2011

**Location of Inquest:** NSW State Coroner's Court sitting at Parramatta Local Court

**Date of Finding:** 19 August 2011

**Coroner:** Magistrate Helen Barry, Deputy State Coroner

### **Representations:**

- **Sergeant Dale Ralph Advocate assisting the Coroner**
- **Mr Rankin appeared for Corrective Services NSW**
- **Mr Mr Gemmell appeared for Justice Health**
- **Mr McKenzie appeared for Mr Griffiths' family**

1. Mr Terry Griffiths was found dead, hanging in his cell at John Moroney Correctional Centre, where he was an inmate, on 3<sup>rd</sup> December 2009. His death was reportable to the Coroner under Section 23 of the Coroners Act 2009 and an inquest mandatory because it was a death in custody.
2. On 4<sup>th</sup> August and 5<sup>th</sup> August evidence relating to his death was heard at Parramatta Coroner's Court. Submissions were heard on 12<sup>th</sup> August 2009. Advocate Assisting was Sgt Dale Ralph. Mr Rankin represented Corrective Services NSW, Justice Health was represented by Mr Gemmell and Mr McKenzie represented Mr Griffiths' family.
3. S81 of the Coroners Act requires that the coroner determine the identity, date, place, cause and manner of death. .This investigation has concentrated on how it came about that, as the post mortem performed by forensic pathologist Dr Brouwer clearly indicates, Mr Griffiths came to hang himself , alone in a cell.

## **FACTS**

4. Mr Griffiths was a 21 year old male of aboriginal origin. He had a lengthy history of mental illness, part of which is contained in five volumes of reports produced by Justice Health. He had a diagnosis of schizophrenia and depression. He had also been assessed with a mild intellectual disability. He also had a long history of non compliance with medication and a history of self harm, references to which appear in the Justice Health files.
5. Mr Robbie John Griffiths, Terry's uncle, told the inquest that Terry had grown up in Armidale. His father was from Armidale and his mother was from Inverell. He had family contacts in both those areas.
6. He is reported to have loved sport, especially touch football, rugby league and cricket. He was well loved by his family and was especially popular with the younger members of his extended family.

7. He also loved art and music and was an accomplished painter of aboriginal paintings and landscapes. In addition he had made a CD. It was a rap song about drug and alcohol. It was to be used as a warning for other young men about drugs and alcohol. Mr Robbie Griffiths stated that Terry was able to express himself through his music. Terry loved to attend family gatherings and loved his grandmother and parents.
8. Terry Griffiths was received into NSW Correctional Custody on 31 May 2008. He had previously been in custody twice before and had been at Kariong as a juvenile. At the time of his death he was serving a sentence of ten months and 30 days. The earliest date for release was 7 January 2010, but he was due to attend Court on 4<sup>th</sup> December 2009 on a number of serious criminal charges.
9. On 22<sup>nd</sup> November 2009 Mr Griffiths was transferred to John Moroney Correctional Centre from Metropolitan Remand and Reception Centre at Silverwater. He was seen by the reception committee on 23 November 2009. On 22 November 2009 he had been seen by Justice Health with a health problem notification form stating that he had a mental health history , currently compliant with medication, and guarantees his own safety . He was cleared to a 2 out cell.
10. On the 30<sup>th</sup> November 2009 he was seen by Christine Luckman, welfare officer who referred Mr Griffiths to the Disability Support Unit. She also contacted Pete Townsend, manager of Aboriginal Classification for support for Mr Griffiths.
11. On 1<sup>st</sup> December 2009 Justice Health issued another health problem notification form ;he was released for normal cell placement.
12. On the 1<sup>st</sup> December , Mr Griffiths was placed in cell 3, a 1 out cell in Archibald House. On the 2<sup>nd</sup> December he attended a group session conducted by Ms Houshmand, psychologist. This was an information session concerning depression, anxiety and psychosis. On the 2<sup>nd</sup> December Mr Griffiths was locked in cell 3 at lockdown. About 8.20am on 3<sup>rd</sup> December during a routine head check , Senior Correctional officer Darren Barlow discovered the body of Terry Griffiths hanging by a

sheet around his throat attached to a fire sprinkler on the ceiling of his cell. CPR was rendered by Senior Correctional Officer Barlow and 1<sup>st</sup> Class Officer Lea. CPR was ceased at 8.26am and Mr Griffiths was announced deceased by Nurse Allan Curtain.

## **THE ISSUES**

1. Was the screening process approving Mr Griffiths return to the main gaol adequate.?
2. Was it reasonable to place a inmate with a history of mental illness, self harm and non compliance with medication in a 1 out cell.?
3. Is the monitoring of prisoners between lockdown and sunrise adequate?
4. Is the use of depot injections an appropriate form of management for a inmate with a history of mental illness and non compliance with medication.?
5. What consideration is given to accommodating inmates, especially those with a history of mental illness, closer to family?

## **The Screening Process.**

13. On 9<sup>th</sup> November 2009 Dr Saboor spoke with Mr Griffiths at the Mental Health Screening Unit at Silverwater gaol. He had been transferred to the screening unit because he was unwell and concerns were expressed about Mr Griffiths' non compliance with medication . When Dr Saboor saw him , the doctor assessed Mr Griffiths and found he was not unwell as there were no symptoms of mental illness.He approved his return to the main gaol. He also noted Mr Griffiths was compliant with medication .He assessed Mr Griffiths for 45 minutes in the company of Nurse Austyn.
14. Dr Saboor also read the Justice Health file relating to Mr Griffiths, but only volume five which.dated from 6<sup>th</sup> September 2009. He acknowledged that within that file there were a number of entries relating to Mr Griffiths' non compliance with medication. Mr Griffiths also exhibited symptoms which were documented and indicated to Dr Saboor that he was suffering hallucination, possible delirium and

agitation. Dr Saboor stated the Mental Health Support Unit was a screening unit only. There was considerable pressure to make speedy decisions to transfer patients out of the unit. Although he could not answer whether it would have been prudent to screen him again after 9<sup>th</sup> November he conceded that given Mr Griffiths' history and diagnosis it would have been more prudent to have acquainted himself with his whole history as contained within the Justice Health files.

15. Dr Saboor did not address the issue of supervised medication but Nurse Austyn gave evidence that when Mr Griffiths left the screening unit it was assumed he would be on supervised medication.
16. Nurse Austyn completed a Mental Health Screening Unit discharge plan based on the interview with Dr Saboor plus input from Corrective Services, welfare and the psychologist file. She noted in the discharge plan that Mr Griffiths had numerous mandatory notifications, due to unusual and aggressive behaviour, self harm ideation, command auditory hallucinations and non compliance with medication. She also noted he acknowledged attempts to manipulate his placement in custody and his non compliance with medication.
17. In the management plan she noted that Mr Griffiths required monitoring of medication and mental state and that he would benefit from supervised medication due to a history of diverting medication and non compliance.

### **Placement in a 1 out cell**

18. Mr Griffiths was received into John Moroney Correctional Centre on 22<sup>nd</sup> November 2009.
19. On 1 December, 2009, Christine Piipari, registered mental health psychiatric nurse approved the placement of Mr Griffiths to a 1 out cell. She gave evidence that before she consulted with Mr Griffiths she examined his notes and read that the Mental Health Screening Unit had performed a mental health assessment on 9<sup>th</sup> November 2009 and found it was appropriate that he be placed in a normal cell placement.

20. She took into account the following considerations in assessing Mr Griffiths, in addition to the Mental Health Screening Unit assessment:

- He told her he wanted to be in a 1 out cell as he was irritated by being with other people and he wanted his own space. She was impressed with the manner in which he was able to articulate his needs into a logical sentence and state his wishes.
- He was co-operative , reactive and denied any suicidal ideation. She believed he was genuine.

21. She made two decisions that day.

22. She allowed him to come off supervised medication and she approved his placement in a 1 out cell. She believed both decisions were appropriate. Notwithstanding the notification in the discharge management plan from the Mental Health Screening Unit dated 10<sup>th</sup> November 2009 concerning Mr Griffiths' acknowledgement about attempts to manipulate his placement in custody, and his non compliance with medication, Ms Piiperi explained that she was very astute at assessing body language and eye contact. She had no trouble believing his guarantees for his safety. Dr Saboor on the other hand gave evidence that it is very difficult to ascertain whether someone is telling the truth.

23. Ms Wright, General Manager DCS described the Corrective Services policy and procedures. 5.2.3 of the John Moroney Correctional Centre standard operating procedures states in part:

*“ the Correctional officer must satisfy themselves that the inmate is alive and well”*

24. Part 5.2.4 stipulates:

*“ An inmate who appears to be affected by drug or alcohol or is otherwise injured or not able to care for themselves must not be locked in a cell”*

25. Natasha Rochford is a Senior Correctional Officer at John Moroney Correctional Centre. She gave evidence that Mr Griffiths and his cell mate and other inmates approached her a number of times on 1<sup>st</sup> December 2009 asking for 1 out cells . She checked Mr Griffiths' health notification form dated 22<sup>nd</sup> November 2009. She did not feel it made sense. That notification signed by M McEvoy Justice Health Nurse, stated "two out cell, currently compliant with medication , denies suicide ideation"
26. Ms Rochford had concerns that the form meant that Mr Griffiths was suitable for a 2 out cell.
27. She asked her supervisor Greg Taylor to review the form. He also thought the health notification form was unclear. He phoned the clinic to get the form "sorted out" and was informed by someone at Justice Health that inmate Griffiths had a clearance for a 1 out cell. A health notification form to that effect was forwarded to DCS.
28. Ms Rochford gave evidence that she cannot override a health notification form , if it says it is a 2 out cell placement.
29. However, she stated if she had concerns she would not have moved him. She had had no previous dealings with Mr Griffiths. The only thing she relied on was the health notification form. She had no access to Justice Health records. There was nothing in Mr Griffiths' behaviour on that day that caused concern.
30. On the day before, however, being 30<sup>th</sup> November 2009 Ms Luckman, Welfare Officer , John Moroney Correctional Centre did have concerns.
31. She spoke with Mr Griffiths for about 20 minutes on that day. She said he was concerned about his upcoming court appearance on 4<sup>th</sup> December 2009. He made no eye contact and was flat in mood.
32. After he left her she did some background checks. She had no access to health reports. She noted Mr Griffiths had had no visits and no telephone contact with his family. She was concerned about his vulnerability.

33. He did not want to engage and was reluctant to give information. She noted that there had been an earlier note that Mr Griffiths was to be referred to the Disability Support Unit.
34. This had not been done so she sent an e-mail to that unit requesting that he be assessed as a priority for the additional support unit at Long Bay. She had concerns for his safety due both to his vulnerability and a previous history of sexual assault in custody.
35. She also contacted Pete Townsend, Aboriginal Classification manager, advising him of her concerns. Her actions are commendable.

#### **The monitoring between lockdown and sunrise**

36. Ms Wright, General Manager at JMMC described John Moroney Correctional Centre as a location where inmates commence the young adult offender programme. She stated that if correctives had any concerns about Mr Griffiths' behaviour, a risk intervention team would have been assembled. This would include a correctives officer, a nurse and a psychiatrist. This team can be assembled immediately if the situation arises. If necessary a inmate can be placed in an observation room.
37. She noted that Mr Griffiths completed the mental health disorder program conducted by psychologist F Houshmand on 2 December 2009. It was reported that Mr Griffiths engaged well in that discussion and his interaction appropriate.
38. As Mr Griffiths had been cleared by Justice Health to be housed in a 1 out cell, and there were no concerns raised by Corrective Services Officers concerning Mr Griffiths' behaviour, his placement in Cell 3 , a 1 out cell was considered appropriate.
39. The only requirement in terms of security and monitoring was for the night senior corrective services officer to arrange and maintain irregular after hours security

patrols. This involved ensuring the unit was secure and does not involve an inspection of each cell door.

40. The only reason staff would enter a cell after lock in is when an inmate activates the cell alarm system or in a emergency such as fire. The cell alarm system can be activated when an inmate suffers mental distress. On 2<sup>nd</sup> and 3<sup>rd</sup> December 2009 there were no activations from cell 3. She further stated that the preferred position was that each inmate have his own cell.
41. Following this tragic event , she stated that there have been no changes in correctives procedures as she believed all protocols had been appropriately followed.
42. She did however state there was a need for an increase in mental health services as there is a high rate of mental health issues in a young adult gaol as well as issues with substance abuse. One mental health nurse one day per week was insufficient to deal with the population.

### **The Use of Depot Injections**

43. Dr Andrew Robertson , consultant psychiatrist reviewed the Justice Health file concerning Mr Griffiths . He noted that the records extended from December 2002 to the time of Mr Griffiths death. He further noted that Mr Griffiths had been diagnosed at the age of 13 with a mental illness. There were episodes of self harm and an extensive history of non compliance with medication.
44. In January – February 2008 he was reported to be well whilst having injections of depot resperidone when in custody. In June 2008, having again become non compliant with medication after his release, he was charged with attempted murder and arson.
45. In the latter half of 2009 again there were reports of his non compliance with oral anti-psychotic medication. Dr Robertson raised the issue that depot injections do not appear to have been considered. He stated in his report:

*“ the only criticism I would make concerning his management is that , given his habit of non compliance with oral medication, and his frequent untruthfulness in relation to the presence of psychotic symptoms, the use of depot injections of anti psychotic medications does not appear to have been considered in the latter part of 2009. When in custody in early 2008 he was having these injections and was said to be well, although he defaulted on having injections after his release from gaol.”*

46. Dr Robertson’s evidence is that Mr Griffiths should have been placed on depot injections before he was transferred to JMCC. If he was then compliant with medications his accomodation in a 1 out cell would have been appropriate given Mr Griffiths’ past history of being sexually assaulted by a cell mate and the possibility of him misinterpreting the actions of a cell mate in a shared cell.
47. Dr Robertson’s concerns related to the issue of non compliance with medication. His evidence was that assumptions could not be made that Mr Griffiths was taking his medication given the evidence of his defaulting which runs right through his history.
48. The most successful way of preventing suicide in persons with schizophrenia is management of their medication. Even if a patient is on supervised medication, Dr Robertson maintained that they can become adept at evading medication. He believed the use of depot injections was not a “big thing”
49. Dr Saboor did not consider depot injections because at the time he saw Mr Griffiths he was not exhibiting any symptoms and Mr Griffiths had told him he was taking his medication as he “had learned his lesson”
50. In order to have depot injections prescribed he would have needed to schedule Mr Griffiths to Long Bay Gaol and there was no reason to schedule him when he saw him on 9 November 2009.
51. The Honourable Greg James QC. President of the Mental Health Review Tribunal gave evidence about the use of depot injections within the framework of a Community Treatment Order in the correctional context.

52. S53 (3) Mental Health Act 2007 provides that the tribunal may make a community treatment order for an affected person if the Tribunal determines that :
- a no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and .
  - b A declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it , and
  - c If the affected person has been previously diagnosed as suffering form a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.
53. Given Mr Griffiths' past history, Mr James stated he believed Mr Griffiths would have benefited from the implementation of a community treatment order which may have authorised compulsory medication, among other conditions, as part of the order.
54. One of the advantages of Community Treatment Orders in the correctional context, according to Mr James, is that enables the inmate to receive treatment and if possible be referred earlier to the main gaol or even to be discharged thus alleviating the burden on services.
55. A concern raised by Justice Health , that a Community Treatment Order may override fundamental human rights of an inmate, especially if the inmate was unwilling to accept depot injections, is not a valid concern.
56. There is no forceful treatment of a patient.in NSW outside a hospital.
57. The purpose of Community treatment orders is to ensure that persons with mental illness whether in the community or in prison have equal access to care and treatment. Safeguards are in place; the community treatment order could only be administered in accordance with the treatment plan approved by the tribunal when it

makes the order. The tribunal maintains a monitoring role in the care of community treatment orders made for an inmate in a correctional centre.

58. Essentially, a person with a mental illness who is an inmate in a correctional centre is entitled to the same level of care and treatment as a person in the community. The use of depot medications in the context of a community treatment order may, in some cases, ensure that a person receives treatment if that person does not have the capacity to consent to such treatment.

59. As Mr James states: 'there is no human right that enforces suicidality'

### **Accommodation near family**

60. Mr Griffiths told Ms Luckman that he had not seen his family . Family was very important to him. This was one of the concerns Ms Luckman had about Mr Griffiths' vulnerability. Ms Wright told the inquest consideration is given to housing inmates closer to family. Initially Mr Griffiths had been housed at Tamworth which is nearer his family. His father had visited him there 5-6 weeks prior to his death. However , Tamworth is only a minimum security prison and once Mr Griffiths was classified as medium security it was not appropriate for him to remain there.

61. Ms Wright's evidence was that the Disability Support Unit completes an assessment and advises where best to accommodate an inmate, and also provides advice as to ongoing support services.

62. A notification on Mr Griffiths' DCS file in March 2009 indicated that he was to be referred to the DSC for assessment.

63. Regrettably, that had not been acted upon. Ms Luckman made a referral on 30<sup>th</sup> November 2009 but Mr Griffiths took his own life three days later before any action could be taken.

64. Ms Wright also spoke of financial assistance, that could be given by DCS to inmates' families if they lived a distance away and wanted to visit on inmate family member.

## **Conclusions**

65. Mr Griffiths' mental health in the weeks preceding his death was not given appropriate or adequate consideration.
66. There should have been alarm bells to those responsible for his mental health assessment, given the extensive documentation relating to his schizophrenia, depression, non-compliance with medication and history of untruthfulness regarding the presence of psychotic symptoms.
67. Dr Saboor acknowledged that in hindsight it would have been prudent to review Mr Griffiths' whole mental health file as contained in the Justice Health Volumes.
68. Also, it would have been prudent for Mr Griffiths to have been again assessed by a psychiatrist prior to his release back to the main gaol.
69. It is clear that this did not take place largely due to limited resources. There are only two psychiatrists present at the MHSU. One works full-time and the other part-time.
70. Dr Saboor spoke of the pressure to discharge persons from the MHSU back to the main gaol. This was clearly an inadequate response for Mr Griffiths who had a history of mental illness dating back to the age of 13 as well as a history of non-compliance with anti-psychotic medication.
71. The Justice Health files record numerous episodes of Mr Griffiths exhibiting symptoms of mental illness. Indeed it was because of such symptoms that Mr Griffiths was transferred to the MHSU in November 2009. One thirty minute assessment without the full knowledge of his history was an insufficient response. His records would have revealed that he was a troubled young man in need of careful monitoring.

72. Nurse Piipari's decision to approve Mr Griffiths' placement in a 1out cell was curious. Not because a 1out cell may not have been appropriate but because of the process she used in coming to that decision.
73. Dr Robertson's evidence was that a 1out cell may well have been appropriate given Mr Griffiths' history of being sexually assaulted and concerns about his responses to the behaviour of cell mates.
74. Ms Piipari, however, based her decision partly on the need to build trust with a person with a mental illness. She did not believe it appropriate to refuse a request of an inmate suffering a mental illness, who displayed no current signs of mental illness. To do so, in her words, would "*do little to engender trust*"
75. Not only did her decision ignore the information contained in the Mental Health Notification report from Nurse Austyn, but she failed to acknowledge the responsibility that should be shown to an inmate in a correctional setting.
76. As Mr McKenzie submitted, when persons are taken into custody, they lose autonomy over their own decision making and care. The State takes a solemn responsibility concerning their care and safety.
77. Trust and non-discriminatory action may be appropriate for persons in the community but for an inmate in a custodial setting, concerns for the inmate's welfare and safety must be paramount.
78. Mr McKenzie further submitted that the Mental Health Services available to Mr Griffiths let him down. I agree.
79. The actions of an individual professional may attract some criticism, but the reality was that there was insufficient staff available to properly assess persons such as Mr Griffiths.
80. There is an abundance of evidence that the number of mentally ill persons in the correctional system is at crisis point.

81. Dr Adam Martin, Clinical Director, Community Mental Health, Justice Health, wrote in his report that at any time the NSW prison population consists of approximately 10,000 inmates. Of those, approximately:
- a. 70% have a personality disorder
  - b. 50% have a substance abuse issue
  - c. 40% have an anxiety disorder
  - d. 40% have post traumatic stress symptoms
  - e. 30% have mood disorders
  - f. 10% have suffered psychosis in the previous year.
82. JMCC has about 250 inmates. Ms Wright stated that the ratio of inmates with mental health issues in the age group of inmates at JMCC is high.
83. Mr McKenzie submitted that consideration be given to more widespread use of depot injections and that a comprehensive study be done on the use of depot injections in the custodial setting.
84. Mr Gemmell did not submit on this point but pointed out that it could not be known if Mr Griffiths would have been in agreement with this method of medication. He further submitted that there was no evidence that Mr Griffiths was not complying with his medication at the time of his death.
85. This may be true; there is no scientific means of measuring the medication post-mortem.
86. What is not in dispute is that currently the best way of managing a person with schizophrenia is with medication. If consideration had been given to the use of depot injections as recommended by Dr Robertson, and Mr Griffiths was in fact being administered his medication in this way then that would have at least provided some comfort to those responsible for his care and offered greater confidence in decisions made about his accommodation placement, especially in view of the evidence that when administered depot injections in the past, Mr Griffiths had remained well.

87. Mr McKenzie further submitted that consideration be given to the making of Community Treatment Orders for inmates who are mentally ill and need to remain in custody. A CTO could be a way of expanding the way in which services can be provided, especially bearing in mind the large number of inmates who suffer mental health incidents.
88. Not only would a CTO establish a clear plan of treatment for an inmate, whilst in the prison population, but it could usefully provide a framework for his ongoing treatment once released into the community.
89. Finally, on the issue of placement of an inmate closer to family. Mr Rankin submitted that Corrections had no dispute with that principle. One of the concerns is the type of prison available which is closest to the inmate's family.
90. Mr Griffiths' family reside in Armidale. Tamworth is closer but is inadequate because it is largely a remand centre and houses inmates with different classifications and there is a lack of mental health services available.
91. Kempsey and Grafton gaols are also closer to Armidale but house inmates with a higher classification than that relating to Mr Griffiths and as such it would not have been in his best interests to place him there.
92. Mr McKenzie acknowledged that JMCC was appropriate for Mr Griffiths because it housed younger inmates and runs excellent programmes for inmates.
93. There clearly exists a tension between the competing interests of appropriateness of accommodation and proximity to family.
94. Mr Rankin submitted that once Mr Griffiths had been assessed by the Disability Support Unit his classification may have changed and his accommodation placement altered. It is also noted that Mr Griffiths was to appear at the Sydney District Court on 4 December 2009.

95. All parties acknowledged the importance of placement and proximity to family, especially in the case of young aboriginal inmates. Again, it was conceded by Mr Rankin and Mr Gemmell that in the case of young aboriginal inmates, the value of family support can never be underestimated and accordingly I make no recommendations in this matter.
96. It can never be known why Mr Griffiths took his own life. It is equally possible that he experienced a return of schizophrenic symptoms as was often the case in the past, or that he was concerned about his upcoming court appearance. Sadly, what is known is that Mr Griffiths was a young man who had struggled with mental health issues for a long period of time and that deficient regard was paid to those issues by Justice Health who was responsible for his mental health care and treatment.

### **FORMAL FINDINGS**

**That Terry Griffiths died on 3 December 2009 at the John Maroney Correctional Centre by hanging himself with the intention of taking his own life.**

### **RECOMMENDATIONS**

#### **To Justice Health**

1. That consideration be given to increasing mental health resources within correctional centres as a matter of urgency.
2. That the MHSU be made a limited purpose declared mental health facility to enable lawful involuntary mental health treatment to be given there for patients who cannot adequately be treated involuntarily otherwise in the correctional system.
3. That consideration be given to the implementation of the legislative provisions for Community Treatment Orders for those within the correctional system and for those leaving the correctional System.

4. That consideration be given to the making of Community Treatment Orders and appropriate health monitoring for persons who have a history of mental illness and who come into the correctional system or are returning from the MHSU.
5. In each case as described above, Justice Health is to liase with classifications and security within the correctional facility to ensure persons are appropriately treated and accommodated to reduce the risk of self harm or harm to others. .

### **ORDER**

I make an order pursuant to section 75(5) of the Coroners Act 2009 permitting the publication of a report of these proceedings.

Magistrate Helen Barry,  
NSW Deputy State Coroner  
19 August, 2011.