LOCAL COURT of NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of Michael MORRIS**
Hearing dates:	14 – 17 March 2011
Date of findings:	May 2011
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner H.C.B. Dillon
Findings:	I find that Michael Morris died on 4 May 2009 at the Nepean Hospital, Penrith, New South Wales as a result of an hypoxic brain injury suffered when he hanged himself in the cells of the Penrith Local Court.
Recommendations:	***To the Minister for Corrective Services I make the following recommendations***:

1. That a system of monitoring prisoners on a regular basis by way of visual check be established in court cells administered by the Department of Corrective Services.
2. That the DCS consider giving increased placement priority to prisoners in court cells who are withdrawing from drugs.
3. That the DCS review its current "knock-up" systems and, following such a review, consider installing systems or mechanisms of recording times and locations of "knock-up" calls from cells, including a system of recording when "knock-up" calls are answered, in the context of other measures designed to promote prisoner safety.

4. That the DCS amend the current Lodgement form to require correctional officers completing the form to acknowledge reading the Custody Management Record and Prisoner / Intoxicated Person Transfer Note received from police custody managers.
5. That the DCS note or record any warnings or alerts contained on those police records on the Lodgement form or some other appropriate DCS document.
6. That the DCS consider instituting a course of training in the recognition and basic management of prisoners withdrawing from drugs for correctional officers located in court cells.
7. That the DCS review its training of officers in 24-hour court cells and implement refresher training if a need for it is identified.

To the Ministers for Police and Corrective Services I make the following recommendations:

8. That the Police Force and the DCS develop a system or protocol for the transfer of full histories of self-harm from the Police Force to the Department of Corrective Services when prisoners are transferred from police to DCS custody.

To the Minister for Health I make the following recommendation:

9. That NSW Health consider the undated report of Dr Hayllar received 11 March 2011 and, insofar as it is useful, review relevant Justice Health policies and procedures in the light of the opinions expressed by him.

Order: In accordance with s.75(5) I authorise publication of my findings and recommendations.

File number: 1213/09

Representation: Mr P. Rowe (Counsel Assisting) instructed by Ms L Darcy (Crown Solicitor's Office)

Mr W. De Mars (Legal Aid Commission) representing Mrs Marion Bargwanna (mother of Michael Morris)

Mr R. Greenhill SC instructed by WG McNally & Co representing Correctional Officers Cliffe and Charlton

Mr M. Spartalis (counsel) instructed by Mr S. Robinson representing the Commissioner of Corrective Services

Mr P. Saidi representing Sergeant D. Sinclair

Mr M. Fordham representing Justice Health

REASONS FOR DECISION

Introduction

Deaths by suicide in custody are preventable deaths. Regardless of the nature of any crimes committed by persons in custody or their characters, it is a statement of the obvious that our society, through it agencies, such as the Police Force and the Department of Corrective Services, owes prisoners a duty of care. Prisons and lock-ups should be safe environments for inmates.

As easy as it is to enunciate such general statements from the Bench, in practice the day-to-day task of ensuring prisoner safety in a gaol or cell complex is difficult. It is difficult not least because the workings of the human mind can be hidden, sometimes even from a person him- or herself, as well as from others.

Nevertheless, it is well-known that suicide rates can be cut by reducing the availability of opportunities for spontaneous or impulsive suicides. Where suicides occur in prisons, it is usually because either a good system has not been established or, if it has, the system has failed in some way.

Michael Morris was a young man of 32 when he died of an hypoxic brain injury suffered as result of hanging himself in the cells at Penrith Courthouse on 3 May 2009 with the drawstring cord from the waistband of his shorts. This is a case of systems failure.

An inquest is an independent judicial inquiry or investigation. In this case, the primary questions have been "How did the death come about?" and "What can we do to prevent similar deaths occurring in future?"

Background

Michael Morris was arrested on 2 May 2009 and charged with Possession of Prohibited Drug [heroin] and Escape Lawful Custody. He was then a prisoner on parole and was facing serving a further approximately 11 months in prison for the balance of his parole period. Mr

Morris had a long history of educational difficulties, family dysfunction and drug-related criminal offences.

Despite these enormous personal disadvantages, it is noteworthy that the police officers who arrested Mr Morris and who held him in custody at Parramatta Police Station pending his transfer to the custody of the Department of Corrective Services – in particular, Detective Nathan Marlin and Sergeant Dane Sinclair – took a relatively benign view of him. Those officers saw in him a young man who was struggling against an addiction that he was unable to manage but who wished to make a better life for himself and his young son. Detective Marlin thought that he had made a decision to use the time he would spend in custody to rehabilitate himself.

As a boy, Mr Morris was hyperactive at school and found the school environment difficult. He was, however, a talented Rugby League player and played under-age representative football. Unfortunately, while playing football he met people who introduced him to drugs and he gradually became addicted with all the self-destructive consequences that frequently follow. Despite all that, he became a devoted and loving father of his son. His addiction and other circumstances fractured and fragmented what might otherwise have been a stabilising and fulfilling aspect of his life.

The real tragedy of this case is that Mr Morris's fundamentally decent instincts and aspirations were snuffed out by his despair – perhaps triggered by the realisation that he was once again to be separated from his young son because of his drug addiction and drug-related offences – and by failures in the correctional system that owed him a duty of care.

The issues

The first duty of a coroner is, if possible, to make findings concerning the identity of a person who has died suddenly or unexpectedly, the date and place of death and the cause and manner of death. By "manner of death" I refer to the circumstances of a person's death: here the question is, "How did the person die?"

In this case, the only difficult question is that last one. It raises further questions that were outlined by Counsel Assisting in his opening address:

1. Why was the cord not removed from Mr Morris's pants by Police or Corrective Services officers?

2. Were the procedures and the facilities at the Penrith Court Cells complex safe for a prisoner at risk, and in particular:

- Why was Mr Morris not searched again by Corrective Services officers when received into custody at the Penrith Court Cells complex?

- Why was Mr Morris not identified as a prisoner at risk?

- Was Mr Morris being properly monitored by Corrective Services officers at the Penrith Court Cells complex in the lead up to his death, whether by CCTV or otherwise?

This is a mandatory inquest under the *Coroners Act 2009*. Parliament has decided to require an inquest into all deaths in custody as our society owes a duty of care to citizens (and others) deprived of their liberty because of legal process. It has recognised that it is desirable to hold government agencies responsible for safeguarding such people in custody to account for the ways they conduct their administrative duties relating to the custody of prisoners. It is also desirable, when things go wrong in the custodial system, to learn the lessons of experience and to rectify faults or systemic failures. An inquest can serve the purpose of highlighting the those systemic failures and lessons learned.

The facts in summary

After his arrest on Saturday 2 May 2009, Mr Morris was searched by police and held in the charge room at the Parramatta Police Station. A foil of heroin was removed from him and, as previously, noted, he was charged with Possession of Prohibited Drug. At that stage, his shoelaces were removed. He was wearing a pair of rugby shorts with a drawstring cord in the waistband. Police officers did not remove it. He was refused police bail and transferred to the custody of DCS at Parramatta Courthouse that evening.

At the Parramatta court cells, DCS officers received the Custody Management Record and a Prisoner / Intoxicated Persons Transfer Note (or "Prisoner Transfer Docket"). The Prisoner

Transfer Docket included a warning that Mr Morris had a previous history of self-harm. The Prisoner Transfer Docket was filed in a DCS file at the Parramatta court cells and was not placed on Mr Morris's personal "warrant" or file that travelled with him in DCS custody. The practice of filing the Prisoner Transfer Docket in the place where the prisoner was received, although apparently common in many DCS facilities, was contrary to established Departmental procedure.

At Parramatta court cells, the senior officer managed the paperwork received from police while another officer conducted a strip-search of the prisoner and examined his or her clothing for contraband. When Mr Morris was received, he was searched by a relatively junior officer, Mr George Denton, who stated to police after Mr Morris had died that he had found the drawstring cord in Mr Morris's shorts but had been unable to remove it because it was sewn into the shorts. He also stated that he had checked with his supervisor, Officer Melaine Bell, who had approved him leaving the cord in the shorts.

Mr Morris stayed overnight at the Parramatta court cells and was transferred to Penrith court cells early the following day to appear before court in a bail hearing by Audio-visual link. He was not further searched upon reception at Penrith and no one examined his shorts. He was, however, interviewed and assessed by Justice Health Registered Nurse Joanne Locke who appears to have spent about one-and-a-half hours conducting her assessment. She applied a number of standards tests as well as observing Mr Morris and applying her own 17 years of experience. The interview took place at about 10 am. She concluded that he was suitable for normal cell placement but noted on a document entitled a "Health Problem Notification" that he was suffering withdrawal symptoms which she assessed at that time as "mild". She gave him medication for those symptoms and prescribed further doses that were to be given in the evening. She also gave him a Ventolin puffer for asthma.

There is a considerable quantity of evidence from police and correctional officers, as well as from Mr Morris's mother, Mrs Marion Bargwanna, suggesting that at least until the late afternoon of 3 May 2009, Mr Morris appeared well and in good spirits and was not an apparent or obvious suicide or self-harm risk. Nevertheless, he had had a long history of self-harm documented in police and DCS records. That information was apparently unknown to the DCS officers who held Mr Morris in custody at Penrith on 3 May, although an alert had been posted on the Prisoner Transfer Docket received from police at Parramatta court cells.

When he appeared before the court, Mr Morris was refused bail and remanded to appear the following Tuesday at Central Local Court by AVL. Ordinarily, if a place is available, remanded prisoners are moved from Penrith cells to a correctional centre once their bail hearings are finished. These movements are managed by the Placements section of the department according to a priority list they develop during each day's activities. Sometimes remand prisoners cannot be placed immediately and are kept in court cells overnight. In Mr Morris's case it appears that a place was not available in a correctional centre according to the Placement section's priorities and he remained at the Penrith court cells until he was found hanging by the cord of his shorts at about 7pm.

His condition was discovered by officers delivering dinners to cells. He was cut down by correctional officers and attempts were made to resuscitate him. An ambulance attended and he was removed to Nepean Hospital still alive but, as became clear at the hospital, having suffered irreversible and fatal brain damage due to oxygen starvation. He was maintained on life support until the following day when he was removed from the system and died.

Withdrawal from heroin runs its course over a period of 7-10 days but tends to peak at 24-48 hours after the last dose. Mr Morris's last dose had been on the afternoon of 2 May. It is likely that his withdrawal symptoms were therefore beginning to peak or at their peak in the late afternoon of 3 May. At some point during the afternoon of 3 May, Mr Morris spoke to Correctional Officer Guy Eagleton about his medication. Mr Eagleton gave evidence that he had told Mr Morris that he would receive his medication with dinner. A prisoner, Mr Mustafa Zikria, gave a statement to police on the day of Mr Morris's death to the effect that no more than 30 minutes before he was found hanging Mr Morris had been pleading with officers for medication. Mr Eagleton's account was that Mr Morris appeared calm and co-operative and did not display any unusual signs indicative of severe withdrawal symptoms. Regardless of which account is correct, it is common knowledge that withdrawal symptoms are painful and disturbing for addicts unless mitigated by other medications. Hence RN Locke's prescription for medications designed to relieve those symptoms.

What were the circumstances of Michael Morris's death?

In one sense, Mr Morris's death came about because he chose to die. He reported to RN Locke during his assessment interview that he felt worthless "all the time". In such a frame of mind he probably could not conceive of the fact that, despite his own low evaluation of his life, he was valued and loved by others. To close the inquiry there would reduce the meaning of Mr Morris's death to his subjective appraisal and would provide no satisfactory answer to the difficult questions his death presents about the management of persons with a high potential for self-harm in custody.

Mrs Bargwanna, when she gave evidence, stated that she had been relieved when Mr Morris had been arrested because she felt that he would be kept safe, whereas out on the streets taking drugs she knew he was in danger. As it turned out, the system was unsafe for Mr Morris.

The "Swiss Cheese" model of accident causation is a model used in the risk analysis and risk management of human systems. It likens human systems to multiple slices of swiss cheese, stacked together, side by side. It was originally propounded by British psychologist Professor James Reason in 1990, and has since gained widespread acceptance and use in healthcare, in the aviation safety industry, and in emergency service organizations. It is sometimes called the "cumulative act" effect.

The holes in the cheese slices represent individual weaknesses in individual parts of the system, and are continually varying in size and position in all slices. The system as a whole produces failures when all of the holes in each of the slices momentarily align, permitting (in Reason's words) "a trajectory of accident opportunity", so that a hazard passes through all of the holes in all of the defences, leading to a failure. (see Figs 1 and 2 below)

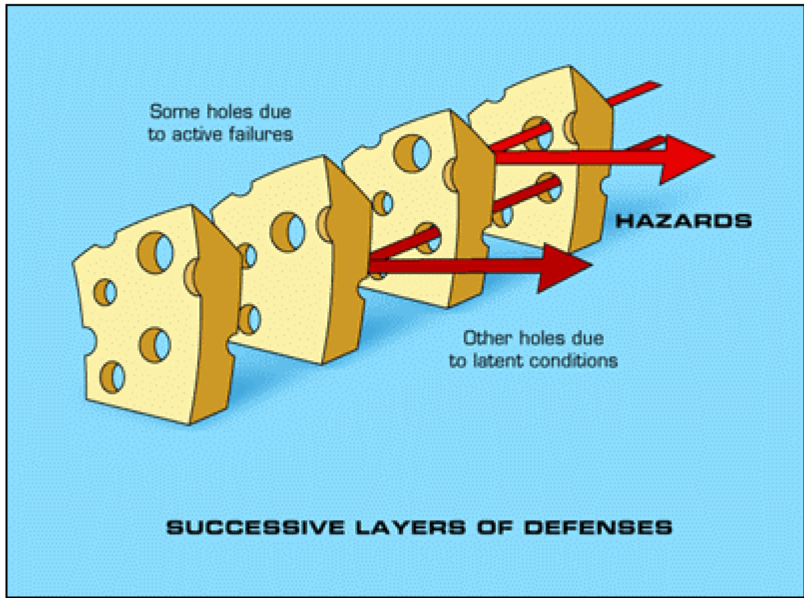

Fig 1. The defence layers work: holes do not line up

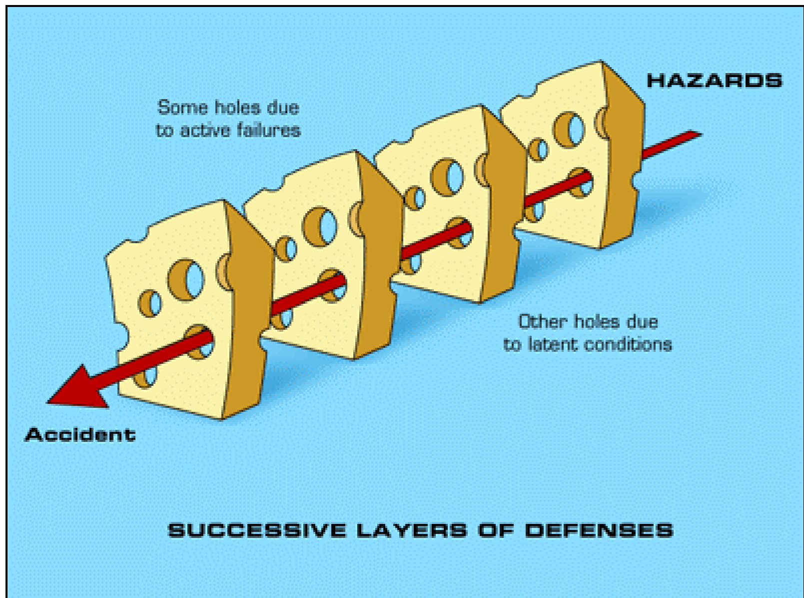

Fig 2. The holes line up: trajectory of accident opportunity[1]

In my view, the model is useful for an understanding of how Mr Morris came to hang himself in the Penrith cells. There were a number of layers of defence built into the system that was meant to prevent Mr Morris from taking his own life. These included searches, warnings about histories of self-harm, assessment by trained Justice Health personnel, medication, CCTV monitoring and the presence of correctional staff trained in dealing with prisoners who

[1] http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html

were obvious risks to themselves. Despite them, Mr Morris managed to find an opportunity to take his own life and the means of doing it. Mrs Bargwanna put it very succinctly when she said that if he had not been placed in a cell with a hanging point with the cord from his shorts, he would probably still be alive.

The system failed in a number of ways, some more significant than others but all of which combined, ultimately, to give Mr Morris the opportunity of hanging himself.

First, and most obviously, if the cord had been taken from Mr Morris, he could not have used it to self-harm. There were a number of opportunities for police and correctional officers to remove the cord. It could have been taken from him by arresting police or the custody manager. It could have been taken from him by correctional officers at Parramatta court cells. It could have been taken from him by correctional officers at Penrith court cells.

The best opportunity to take the cord was probably at the Parramatta cells when Mr Morris was received into DCS custody and was thoroughly searched. According to Correctional Officer Denton he thought about taking the cord and attempted to do so.

It is not entirely clear why he attempted to do so because, at that time, DCS operational procedures only required cords to be removed if a prisoner was "detoxing" or was recognised as otherwise being "at risk". Mr Morris was not thought by police or DCS officers to be "at risk" at that time and was not apparently "detoxing".

Further, it is not clear how vigorous or skilful officer Denton's efforts to remove the cord actually were. In his evidence during the inquest, he exhibited a very poor recollection of events and appeared unable to provide any satisfactory explanation of the fact that he had been incapable, he said, of removing the cord but Mr Morris had been able to do so in the Penrith cells the next day. I examined the shorts and they appeared to be undamaged.

In any event, the cord was not removed either at Parramatta or at Penrith. Mr Denton ought not be scapegoated or required to shoulder the entire responsibility for this line of defence being penetrated because the rules as they then stood did not require the removal of the cord and other officers could also have removed the cord had they chosen to do so because of the potential risk it posed.

Second, whatever view one takes of officer Denton's evidence, as I have noted above, DCS policy in May 2009 did not require cords to be removed in these circumstances. (That policy has now been changed and it is mandatory to remove potential ligatures from all prisoners received into DCS custody.) The flaw in the system was not so much in an individual officer's performance of his duties but in the systemic assumption (at that time) that unless a prisoner showed obvious signs at the time he or she was strip-searched that he or she was at risk, or there was a clear and unambiguous alert given to the searching officer that the prisoner was at risk, there was no need to remove the potential ligature and that the need would not arise later.

Third, the cell into which Mr Morris was placed in Penrith had a convenient hanging point.

Fourth, monitoring systems and practices at Penrith cells in 2009 were inadequate for the task of maintaining the safety of more than one "at risk" prisoner at a time. There were only two CCTV monitors in the cell complex, only one of which was able to monitor the cells. At that time, if a prisoner was identified at Penrith cells as being at risk of self-harm[2], he or she was placed in a cell and a watch was kept on that prisoner by CCTV in his or her cell. The single monitor available to maintain surveillance on the cells was devoted exclusively to that task. Other cells were not monitored by CCTV during the period that prisoner was kept under surveillance.

There was no system at that time of switching views on the CCTV monitor from the "RIT" cell to other cells even on an occasional basis although the technology had the facility for this to be done using the remote control. Nor was there any regular face-to-face inspection of cells and prisoners by officers while the CCTV cell monitor was trained on the "RIT" prisoner. This obviously lent Mr Morris an opportunity to pull out the cord from his shorts and to set a noose from the hanging point behind the door of his cell undetected. (To add further complexity to these circumstances, Mr Morris also managed, without detection, to blind the CCTV camera in his cell using wet paper before hanging himself. Because the monitor was fixed on another cell, this had no ultimate effect but was another breach of the defences.)

Fifth, although the Justice Health "Health Problem Notification" document filled out by RN Locke and given to DCS highlighted the fact that Mr Morris was in withdrawal (although

[2] Such prisoners were called "RIT" or "Risk Intervention Team" prisoners.

only mildly at 10am), the fact that much worse symptoms were likely to develop later in the day or evening does not seem to have registered with DCS staff at Penrith. Although during the course of submissions I was told that he had resiled from this position, Correctional Officer Jason Charlton suggested during his evidence that the correctional officers were not adequately trained in recognising and managing "detoxing" prisoners although they are generally well-trained in managing "RIT" prisoners. His observation was supported by Mr Brian Bartlett, a senior officer with DCS.

Sixth, there were worrying indications that some junior correctional officers may not be adequately trained in important procedures. For example, as I have noted above, we learned that Prisoner Transfer Dockets were routinely filed at a prisoner's place of reception rather than travelling with his or her file. Officers gave evidence that this was how they had been taught to deal with that document by their supervisors. This suggests that most officers learn from one another rather than by familiarising themselves with operations manuals. Indeed, this is probably the way most people learn to do most things requiring the application of some skill or procedure. While "learning by doing" or on-the-job training is, by and large, a highly effective form of training, it is imperative that the right ways of doing things be taught and learned.

I observed a couple of examples of procedures being followed without apparent thought being given to the rationale for those procedures. As previously noted, the Prisoner Transfer Docket was filed rather in the manner of a receipt rather than being assessed for its potential value as information about a prisoner's potential for self-harm. On Mr Morris's docket, the police had provided a warning to DCS that Mr Morris had a previous history of self-harm – potentially very important information that may have altered DCS's assessment of him. Yet that warning was effectively ignored.

An officer conducting the "lodgement" process was required to conduct a *visual* assessment of the prisoner. Included in the checklist of matters to be considered was an examination of the prisoner's neck and wrists for scars, indicating previous attempts at self-harm. Officer Chea spoke to Mr Morris through his cell door at Parramatta and asked him whether he had such scars but did not look at his wrists or neck. This seems to suggest that she had not been adequately trained in the underlying reasons for *looking* at the prisoner. Mr Morris told her that he did not have any wrist scars. That was untrue. He had previously scarred them in self-harm attempts but this went unnoticed at Parramatta. As I have previously noted, there

was no further search at Penrith and there was no further back-up check for signs of self-harm except by Justice Health.

Seventh, it is also problematic that a prisoner in Mr Morris's position – on remand, withdrawing from heroin, serving his balance of parole – was left in courthouse cells for two successive nights without access to medical care once the Justice Health nurse's shift had ended. I accept that there is a resource issue. In raising the issue, I do not criticise individual officers. It is, however, an unsatisfactory situation. It is no secret that NSW prisons are now largely populated by drug-affected and mentally ill (sometimes both) prisoners. Many of them are, almost by definition, at risk of self-harm especially in the early days of their incarcerations. If we are to expect Justice Health and the DCS to care adequately for these populations, it is a statement of the obvious that they must be adequately resourced by government to do so in the current custodial settings or, alternatively, other less resource-intensive means need to be found to cope with the problems such populations present.

I note that in a recent edition of the ABC program "Lateline", the Attorney-General, Mr Greg Smith SC, expressed grave concerns about the size of the NSW prison population, stating,

> A couple of years ago, Premier Nathan Rees seemed to think it was a badge of honour to have over 10,000 people in jails. I thought it was a disgrace. And it just reflects either that we've got a lot more crime in this state [than Victoria] or that somehow our policies on sentencing have been skewed… We need to divert as many people as we can from the system, people with problems, such as people with mental issues, and in the case of people with drug addiction, I want to set up a 300-bed, serious drug place where we can rehabilitate them intensively so that we can get them off drugs.[3]

That is a very wide and deep policy issue which is beyond the scope of this inquest to address except to applaud the Attorney's approach but it is worth observing that the decision to leave Mr Morris overnight at the Penrith cells without access to 24-hour medical care in a prison or, even better, a dedicated drug rehabilitation centre of the type being proposed by the Attorney-General, may have increased his vulnerability to suicidal ideation or other tendencies to self-harm as his withdrawal symptoms intensified.

All of these things said, as Mrs Bargwanna herself recognised, this is in essence a simple case. If Mr Morris had had the cord removed from his shorts, it is more than likely that he would still be alive today and, with luck, be undergoing intensive drug rehabilitation.

[3] Transcript *Lateline* 06/04/11 http://www.abc.net.au/lateline/content/2011/s3184344.htm

What has been done to reduce systemic risk?

Evidence was given that considerable efforts had been made by DCS to reduce systemic risk at the Penrith cells and in the wider custodial system. I accept that Mr Morris's death was a shock for the police and correctional officers most directly involved with his custody. I also accept that the DCS has learned from the experience and sought to implement some changes as a result of lessons learned from the incident.

It is now mandatory that potential ligatures be removed from all prisoners taken into DCS custody. I should emphasise that this is not a cause for congratulation – and I do not believe that the Department expects it – but a commonsense measure surprisingly not implemented before Mr Morris's death.

CCTV monitoring has been improved at the Penrith cells: extra monitors have been installed enabling correctional officers to view prisoners in all cells simultaneously.

What more should be done?

In my opinion, a number of further improvements in the system are called for. First, a scheme of monitoring prisoners on a regular basis by way of visual check would be a significant improvement on the current ad hoc practice. I am conscious that correctional officers often have many duties to attend to such as loading and unloading trucks, processing prisoners, serving meals, administering medications and monitoring "RIT" prisoners. I am also conscious that prisoners in cells can be very demanding and attention-seeking and that an officer walking down a corridor in a cell complex can be bombarded with requests and demands for attention to trivial as well as significant issues. It was implicit in officer Cliffe's evidence that he sought to avoid unnecessary exposure to demands from prisoners.

While that is entirely understandable from one perspective, if there is no reasonable alternative means of maintaining a careful watch over prisoners, a system designed to keep prisoners safe from self-harm is liable to fail.

I have learned from experience conducting inquests into deaths in psychiatric units that one means used by NSW Health to maintain a safe environment for risky patients is for nurses to

conduct regular checks on them, in some cases at 15-minute intervals. As there are similarities between the populations of psychiatric units and many persons in court cells, a system of regular checks on prisoners in cells, especially in the initial stages of being confined in custody, would add an additional layer of defence against self-harm. I propose a recommendation to that effect. I understand that this recommendation is supported by the Department.

A further layer of defence against self-harm could be instituted if prisoners identified in court cells as withdrawing from drugs were given increased priority for placement in a correctional facility to enable them to be given 24-hour medical care if needed. In the light of Mr Morris's experience, in my draft findings I proposed a recommendation that the Commissioner of Corrective Services considers re-ordering priorities for placement of prisoners undergoing drug withdrawal. Counsel for the Department of Corrective Services has informed me that the Commissioner has initiated a project to develop strategies to streamline the movement of prisoners from court cells to correctional facilities. It was submitted that the Department would need to be guided by Justice Health in respect of the severity of withdrawal symptoms and that there was no need to reconsider the system beyond that proposed by the Commissioner.

I agree that the primary assessment of drug withdrawal symptoms is a medical matter for trained clinicians. The general point this case demonstrates is that drug withdrawal is a volatile process in which prisoners may suffer physical and psychological pain of increasing severity and, therefore, that the risk of self-harm is also likely to vary over time. This suggests to me that there is a potential need for such prisoners to be monitored and perhaps treated over a 24-hour period or longer. Hence the need to move them to facilities where such clinical monitoring is available. I support the Commissioner's plan but will make the recommendation as drafted.

As mentioned earlier, the new government has promised that it would establish a Metropolitan Drug Treatment Facility capable of housing 300 prisoners. This would be in addition to the Parklea facility catering to Drug Court referrals. The Legal Aid Commission has submitted that I should recommend that the DCS ought consider using that facility for "the timely receipt and treatment of inmates from police and court cells" who are in the process of drug withdrawal or who are likely to be withdrawing from drugs shortly after being taken into custody. As the new centre has not yet been built and may take some time to

establish, I do not propose a formal recommendation – by the time it is running, such a proposal may be obsolete. Nevertheless, all other things being equal, this seems to me to be a meritorious proposal worthy of consideration.

I proposed a draft recommendation that the DCS (and, where appropriate, the Commissioner of Police) install systems of recording times and locations of "knock-up" calls from cells, including a system of recording when the knock-up call is answered. This recommendation has been opposed by the Department of Corrective Services as requiring a substantial capital investment that is not justified. It was also submitted that even the exercise of reviewing this proposal would be costly. No estimate of the costs either of upgrading the systems or of reviewing the systems has been offered.

The ultimate point of that proposal is prisoner safety and accountability of the custodians. If prisoners are indeed properly monitored and "knock-up" calls are answered, such a system would ultimately not only provide protection for prisoners but for correctional officers against allegations of neglect or misconduct. I appreciate that substantial costs may be involved in such upgrades and that a cost-benefit analysis is needed: there may be higher priorities for such expenditures. I therefore propose that a review be conducted and that the Department *consider* upgrading the "knock-up" system as proposed in the context of other measures designed to promote prisoner safety.

A further recommendation I proposed in draft was that the Lodgement form filled in by correctional officers when receiving prisoners from police custody be amended to require the officer undertaking that exercise to acknowledge reading both the Custody Management Record and the Prisoner Transfer Note and any warnings or alerts contained on those records and to note those alerts or warnings on the Lodgement form or in some other attached document. These recommendations have been supported by the Department of Corrective Services.

I further proposed a draft recommendation that the Commissioners of Police and Corrective Service develop a system of integrating recorded histories of self-harm contained in their records ("static self-harm factors") with any current observations or alerts of risk of self-harm at the time prisoners are transferred from Police to Corrective Services custody. In making this proposal, I do not mean to suggest a method by which this process should be carried out, much less the expenditure of vast capital funds on an integrated computer records system.

Rather, my intention is to suggest that Police custody managers check police records for histories or alerts of self-harm and specify them in the Prisoner Transfer Note or the Custody Management Record as well as noting any other signs or indicators of potential or immediate risk of self-harm by prisoners being transferred to Corrective Services. Once the prisoner is received, a search of Corrective Services records should also be undertaken for histories or warnings of self-harm. Had officers at Parramatta or Penrith been aware of Mr Morris's extensive past history of self-harm, this may have acted as a warning to monitor him carefully.

Mr Morris was not identified as a person at risk until he was found hanging in his cell. It is self-evident, however, from the fact that he sought to take his own life that he was either at risk throughout his time in custody or became so some time during the afternoon of 3 May. Yet this was never identified. Mr Spartalis commented at one point during the proceedings that if all drug-related and mentally ill prisoners were counted as being at risk this might cover 90 per cent of the prison population. Possibly so. (And the Attorney's remarks on Lateline are particular pertinent in this context.) Yet experience in the coronial jurisdiction and the criminal jurisdiction of the Local Court suggests that suicides and self-harming conduct quite often take place during the early stages of a prisoner's confinement when he or she is undergoing the sudden shock of loss of liberty and may be withdrawing or suffering symptoms of untreated mental illness.

The Commissioner of Police was not identified as an interested party to the proceedings and did not seek leave to appear. This suggested recommendation obviously has implications for the Police Force. The Department of Corrective Services has informed that it "will give consideration to an arrangement between the NSW Police Force and Corrective Services in relation to the transfer of information relating to histories of self-harm subject to the views of the NSW Police Force." I therefore propose that, instead of the draft recommendation, the Commissioner of Police and the Department of Corrective Services develop a system or protocol for the transfer of full histories of prisoner self-harm from the Police Force to the Department when prisoners are transferred from police to DCS custody.

It was submitted to me that I should not make any recommendation concerning training of correctional officers in recognising and managing prisoners withdrawing from drugs because that would increase their level of responsibility without properly equipping them to address the issues. That position was reiterated in the written submissions I received after issuing

draft findings and recommendations. It was emphasised that officers already undertake a "Safe Custody" course. It was said, correctly, that the identification and management of drug withdrawal is a medical issue and that correctional officers should be guided by Justice Health officers. It was also pointed out to me that the training of correctional officers is to call for medical help if they see someone in distress and that therefore it is inappropriate to require that correctional officers be trained in recognising or managing drug withdrawal symptoms. The Department does not support a recommendation that would lead to correctional officers taking on roles or responsibilities that are the normal domain of clinicians. With respect, this submission appears to me to miss the point. It is not to unduly load the officers with the responsibility of caring for and treating prisoners but to assist them in recognising when to call for medical help and to take basic steps to prevent harm or further harm until that help arrives.

As Correctional Officer Charlton noted, correctional officers are well-trained in managing prisoners who evidence signs of potential self-harm. It seems to me that there is no difference in principle in training officers to deal with such problems, which are commonplace unfortunately in the system, and training them about the signs to watch out for in prisoners who are or may be suffering withdrawal symptoms, another commonplace problem I would have thought, and the procedures to be adopted when such a prisoner is identified. Some prisoners may seek to feign or exaggerate symptoms but this is the case at present. RN Locke gave evidence that she would expect such a prisoner to be brought to her for assessment. Such training would, however, only be of use if a previous recommendation that prisoners be regularly visually checked were also implemented.

Ultimately, the better-trained correctional service staff are, the better they will do their jobs and, all other things being equal, the safer will be the prisoners. A number of officers and one ex-officer appeared to me to be upset by Mr Morris's death. There can be little doubt that a death in custody places a significant strain on correctional staff, not least because they become the subject of a coronial investigation in the aftermath, but also because decent officers will inevitably feel a sense of responsibility and failure when a prisoner takes his or her life on their watch. A safer system is therefore of benefit to correctional officers as well as to prisoners. I will make the recommendation as drafted and hope that the Department will reconsider its opposition to the proposal.

Training is a key issue. The Legal Aid Commission has submitted that I should recommend that officers posted in 24-hour court cells be given appropriate refresher training in relation to the lodgement and reception process with particular emphasis on;

- Obligations in relation to completing Lodgement forms (PDFs) thoroughly
- Checking current and inactive alerts on the OIMS system and noting them on the Lodgement form
- The mandatory requirements in relation to Custody Management Records and Prisoner Transfer Dockets
- The need to take into account police alerts and warnings as well as DCS alerts in considering risk factors.

Refresher training may also be needed in respect of the proper keeping of cell registers and the procedures relating to movement of prisoners between cells.

There is some overlap here with some of my previous proposals. I am also unaware of how widespread the need for systemic refresher training is now. The need for it could be assessed by DCS management in the light of these findings. I propose to recommend that DCS review its training of officers in 24-hour court cells as suggested above and to implement refresher training if such a need is identified. This recommendation is supported by the Department.

The Legal Aid Commission made a number of proposals for review of Justice Health's policies and procedures concerning prisoners withdrawing from drugs. These appear to be based in large part on a report it had obtained from Dr Hayllar. While it was served on the interested parties, because it was provided to the court only at a very late stage and may have caused unfairness had it been admitted, I did not admit it into evidence. Dr Hayllar appears to have significant experience and expertise in relation to the management of people withdrawing from drugs. The cogency of the opinions stated in the report have not been tested and Justice Health's policies and procedures were not the focus of this inquest. I do not, therefore, propose to make the recommendations suggested by the Legal Aid Commission. Nevertheless, the report may be a document useful to Justice Health in assessing its policies and procedures. Without endorsing the report, I propose to recommend that NSW Health consider it and, insofar as it useful, review relevant Justice Health's policies

and procedures in the light of the opinions expressed by Dr Hayllar. There has been no opposition to the proposal from NSW Health.

Conclusions

In conclusion, I turn back to the issues raised by Counsel Assisting in opening the inquest:

1. Why was the cord not removed from Mr Morris's pants by Police or Corrective Services officers?

2. Were the procedures and the facilities at the Penrith Court Cells complex safe for a prisoner at risk, and in particular:

    - Why was Mr Morris not searched again by Corrective Services officers when received into custody at the Penrith Court Cells complex?
    - Why was Mr Morris not identified as a prisoner at risk?
    - Was Mr Morris being properly monitored by Corrective Services officers at the Penrith Court Cells complex in the lead up to his death, whether by CCTV or otherwise?

The most plausible answer to question 1 appears to be that no one who had custody of Mr Morris at Parramatta Police Station or court cells considered it necessary at that time to remove the cord because Mr Morris did not appear to be at risk and because the procedures or instructions then applicable did not require the cord to be removed when Mr Morris was received into DCS custody.

The short answer to question 2 is that there were flaws in the procedures operating at Penrith court cells in May 2009 and the cell in which Mr Morris was placed was unsafe for a prisoner in possession of a ligature.

It appears that Mr Morris was not searched on his reception at Penrith cells because Penrith correctional staff relied on the fact that Mr Morris would have been searched at Parramatta cells and they assumed that the search at Parramatta would have removed any items constituting a potential risk of harm from his possession. They also relied on the fact that he

did not appear to be at risk and had been assessed by RN Locke as suitable for normal cell placement. To state the obvious, there was simply no procedure at Penrith requiring that prisoners received from other DCS locations be searched again.

The question of why Mr Morris was not identified as a prisoner at risk is more complex. Certainly, at a number of steps along Mr Morris's path from the time of his arrest, Police, Correctional Services and Justice Health staff took steps to attempt to assess whether Mr Morris was in fact at risk of self-harm. It is evident that for most of the time Mr Morris was in custody on 2 and 3 May he did not raise an alarm or cause anyone to suspect that he was at genuine and immediate risk of self-harm.

It may be that his decision was made relatively quickly and fairly spontaneously shortly before he hanged himself. On the other hand, given his history of self-harm, perhaps thoughts of suicide were always close to the surface of his mind if not always consciously present. It is possible that as his withdrawal symptoms intensified during the late afternoon of 3 May they brought with them suicidal ideation. If, as Mr Zikria asserted to police, Mr Morris had been pleading for medication during the last 30 minutes before he was found hanging, this would certainly suggest he was then at risk, regardless of his situation the day before or earlier during that day.

He was not identified at that stage as being at risk because, among other reasons, he was not monitored in his cell. Even if he had been, the risk may not have been identified. If Mr Eagleton's evidence that he was asking about medication some time before dinner is an indication that his withdrawal symptoms were re-emerging, he was at potential risk. This was not identified at the time by Mr Eagleton because Mr Morris did not appear to Mr Eagleton to be in distress and because, although I make no criticism of him, Mr Eagleton was not trained to recognise the request for medication as a possible sign of a prisoner at risk. The same comment applies to all correctional officers at Penrith at that time.

Another possible reason Mr Morris was not identified as a prisoner at risk is that, apart from one brief conversation between him and Mr Eagleton and a conversation that led to him being moved from one cell to another, he appears to have had very little interaction with correctional officers at all because there were no regular checks conducted on prisoners. As I have noted above, the system of monitoring prisoners was significantly flawed.

Headway has been made in improving the safety of prisoners. It is encouraging to note that the Prison Officers' Vocational Branch is a vociferous advocate of improved facilities and procedures and that DCS management has responded to many concerns this case raises. Nevertheless, it is tragic that so high a price has been paid for the lessons learnt.

It has been observed by insiders and observers of our criminal justice system that our prisons now serve the function that once was carried out by psychiatric hospitals: segregating the mentally ill and drug-addicted from the rest of society. As I have noted above, however, the new Attorney-General has outlined a new approach to sentencing policy and the rehabilitation of prisoners which seeks to regain a balance between punishment of offences and the rehabilitation of offenders, especially the mentally ill and drug-addicted. From my perspective as a magistrate of 15 years experience, as well from the perspective I have gained as full-time coroner presiding over a significant number of death in custody inquests, this is a most encouraging policy turn in this field. If fully implemented it may lead to a reduction of deaths in custody, reduced drug-induced crime and the mending of broken lives. It is in this new context that I offer the recommendations that follow my findings.

Finally, it has been said that "for [grief] there is no remedy provided by nature". I realise that an inquest can provide little comfort for the family who have lost a young man but I hope they will know that the lessons learned in this case will probably save the lives of others. I offer my most sincere respects and condolences to Mr Morris's family.

Findings under s 81

I find that Michael Morris died on 4 May 2009 at the Nepean Hospital, Penrith, New South Wales as a result of an hypoxic brain injury suffered when he hanged himself in the cells of the Penrith Local Court.

Recommendations under s 82

To the Minister for Corrective Services I make the following recommendations:

1. That a system of monitoring prisoners on a regular basis by way of visual check be established in court cells administered by the Department of Corrective Services.
2. That the DCS consider giving increased placement priority to prisoners in court cells who are withdrawing from drugs.
3. That the DCS review its current "knock-up" systems and, following such a review, consider installing systems or mechanisms of recording times and locations of "knock-up" calls from cells, including a system of recording when "knock-up" calls are answered, in the context of other measures designed to promote prisoner safety.
4. That the DCS amend the current Lodgement form to require correctional officers completing the form to acknowledge reading the Custody Management Record and Prisoner / Intoxicated Person Transfer Note received from police custody managers.
5. That the DCS note or record any warnings or alerts contained on those police records on the Lodgement form or some other appropriate DCS document.
6. That the DCS consider instituting a course of training in the recognition and management of prisoners withdrawing from drugs for correctional officers located in court cells.
7. That the DCS review its training of officers in 24-hour court cells and implement refresher training if a need for it is identified.

To the Ministers for Police and Corrective Services I make the following recommendation:

8. That the Police Force and the DCS develop a system or protocol for the transfer of full histories of prisoner self-harm from the Police Force to the Department of Corrective Services when prisoners are transferred from police to DCS custody.

To the Minister for Health I make the following recommendation:

9. That NSW Health consider the undated report of Dr Hayllar received 11 March 2011 and, insofar as it is useful, review relevant Justice Health policies and procedures in the light of the opinions expressed by him.

Magistrate Hugh Dillon
Deputy State Coroner