REPORT BY THE NSW STATE CORONER INTO

First Nations People's Deaths in Custody in NSW

2008–2018

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Aboriginal and Torres Strait Islander peoples should be aware that this publication contains the names of deceased persons.

The NSW Coroners Court acknowledges the traditional custodians of the land on which we work and live.

We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging; and recognise the strength and resilience of Aboriginal people in this land.

HELP AND SUPPORT

This report considers issues related to death, self-harm and suicide.
If you need support please contact one of the below support services, and in an emergency, dial 000.

Lifeline (24/7 crisis support and suicide prevention services) **13 11 14**

Beyond Blue (24/7 advice, referral and support from trained mental health professionals) **1300 22 4636**

Suicide Call Back Service (24/7 counselling and support for people at risk of suicide, carers and bereaved) **1300 659 467**

Griefline (midday-3am 7 days a week, telephone and online counselling service for people experiencing loss or grief) **1300 845 745**

Further resources are available at: **https://www.ruok.org.au/findhelp**

TERMINOLOGY

This report adopts the terminology of First Nations people in recognition that Aboriginal and Torres Strait Islander people are the sovereign people of Australia. This term also recognises the various language groups as separate and unique sovereign nations. (Common Ground, 2020).[1]

1 At https://www.commonground.org.au/learn/aboriginal-or-indigenous.

STATE CORONER'S FOREWORD

In October 1987 the Australian Government established the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC). This inquiry was called as a consequence of Aboriginal and Torres Strait Islander community advocacy and concern around the high levels of Aboriginal and Torres Strait Islander peoples' deaths while in the custody of state institutions.

The Commission sought to examine, *inter alia*, the social, cultural, and legal factors that appeared to have bearing on the deaths of Aboriginal and Torres Strait Islander people, focusing its inquiry on the cases of ninety-nine First Nations people who died in police custody, prison or juvenile detention.

The Commission reported that examining the lives of those ninety-nine people showed that '*facts associated in every case with their Aboriginality played a significant and in most cases dominant role in their being in custody and dying in custody*.'[2] RCIADIC delivered its findings by way of final report in April 1991. It made 339 recommendations, several of which directly relate to the role of the coroner, resulting in a variety of changes within this jurisdiction, including the requirement of mandatory inquests into deaths in custody, deaths in police operation, and the public reporting of those inquest findings.

I present this report in addition to the *Deaths in Custody and Deaths in Police Operation* reports, prepared annually pursuant to s37 of the *Coroners Act 2009* (NSW). Despite the changes that resulted from RCIADIC, many of its 339 recommendations remain unimplemented, or under-implemented. Aboriginal and Torres Strait Islander people continue to be overrepresented in custodial populations, and continue to be overrepresented in every category of death that is dealt with by this court. It is in light of these issues, as well as in recognition of Aboriginal and Torres Strait Islander peoples' ongoing advocacy and resilience, that I present this report as a small contribution to improving accountability and transparency around first peoples' treatment in custodial settings.

Teresa O'Sullivan
NSW State Coroner
March 2021

2 Commissioner Johnston, Volume 1, Section 1.1 The Royal Commission, *Royal Commission into Aboriginal Deaths in Custody*, available at http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/7.html.

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01.
INTRODUCTION

This report is designed to be read alongside the *Deaths in Custody and Police Operations* reports prepared by the Office of the State Coroner and tabled annually in each House of Parliament pursuant to s37 of the *Coroners Act 2009* (NSW).

The first section of this report outlines the study's methodology.

The second section of this report presents data relating to Coronial Findings and Coronial Recommendations for deaths that occurred in the period 2008-2018, as well as substantive data regarding the characteristics of First Nations people's deaths in custody, and some limited comparative data with non-Indigenous deaths in custody.

Annexed to this report is a table of all recommendations made in coronial inquests into First Nations people's deaths in custody that occurred during the review period together with the publicly available responses to those recommendations as at the time of writing.

METHODOLOGY

Inclusion criteria

This report examines the deaths of all people who died in custody[3] in NSW between 1 January 2008 and 31 December 2018. The dataset includes the deaths of all persons where the person died –

- While in the custody of a police officer or in other lawful custody (s23(1)(a);
- While escaping, or attempting to escape, from the custody of a police officer or other lawful custody (s23(1)(b);
- While in a detention centre, correctional centre, or lock-up of which the person was an inmate (ss23(1)(d)(i)-(iii)); or
- While proceeding to one of the above institutions for the purpose of being admitted as an inmate (s23(1)(e)).

The dataset does not include deaths that are determined to have occurred as a result of police operations (for example, motor vehicle deaths that occurred in the context of a police pursuit).

This report primarily focuses on the deaths of First Nations people who died in custody, providing limited comparative data with the broader dataset of all s23 deaths that occurred in custody as per the definition above.

Case identification

Three major data sources were used to identify the cohort of s23 deaths in custody examined in this report:

- the National Coronial Information System (NCIS);
- the annual Deaths in Custody and Police Operations reports prepared by the State Coroner and tabled in each House of Parliament pursuant to s37 of the *Coroners Act 2009*; and
- JusticeLink- the web based electronic case management system used for court administration in NSW Local, District and Supreme Courts.

Firstly, an NCIS report was prepared with a query design that identified all open and closed cases where the deceased person was coded as a 'prisoner' under their employment status. NCIS attachments for each case were accessed to determine the accuracy of the coding in each entry. All cases identified on NCIS were cross-referenced with JusticeLink and with the cases set out in the relevant s37 report to confirm that the matter was a death in custody in accordance with the above inclusion criteria. For open cases, JusticeLink records and the open list included in the s37 report were used to confirm that the case was being progressed as a s23 matter as per the case inclusion criteria above.

Secondly, each annual *Deaths in Custody and Police Operations* s37 report that was published between 2008 and 2018 was examined to identify all cases that were finalised as a death in custody, as well as s23 matters that remained open within the coronial jurisdiction. This report provides an overview of s23 deaths in custody as well as coronial findings for such matters that were finalised within the preceding year. Where de-identified in the s37 report, reported cases were re-identified via examining JusticeLink records based on available identifying details (such as the date of inquest finding).

For the purposes of identifying First Nations people's deaths in custody, 'Indigenous or Aboriginal and/or Torres Strait Islander status'[4] was coded based on data contained in NCIS, JusticeLink and information available within the s37 report. This data did not always match, and where a person was identified as Indigenous or Aboriginal and/or Torres Strait Islander in one of the datasets, the full coronial brief was examined to establish and confirm the deceased's First Nations identity.

3 As defined under s23 of the *Coroners Act 2009* (NSW).
4 This is the language adopted in the majority of databases.

Data collection and coding

The data sources identified above were used to generate demographic and case characteristic data for the whole dataset of s23 deaths (non-Indigenous and First Nations people), including the deceased's age, sex, country of birth, Indigenous status, manner and cause of death, location where the deceased was being lawfully detained, and the case status (open/closed).

For all cases where the deceased in a s23 death in custody was identified as a First Nations person, the full coronial file/brief of evidence was accessed from government records or, for open cases, the brief was examined at the NSW State Coroner's Court. A four case pilot was utilised to undertake exploratory data capture and a quantitative data sheet was developed from this process and was thereafter filled out for the purposes of this study.

Limitations

Several data issues may impact the accuracy of the data in this report.

Firstly, there is no specific query design in NCIS or JusticeLink capable of generating the dataset used in this report, and while 'prisoner' employment status may be a useful proxy within the NCIS database, this does not accurately identify persons in police custody or other forms of custody such as persons scheduled under the *Mental Health Act 2007* (NSW). Combining the datasets assisted in the process of attempting to overcome this data issue.

Secondly, NCIS data and the s37 reports are not always reliable in terms of a identification of a deceased as a First Nations person, particularly where matters remain open or a deceased person was not so identified in the coronial finding. While two sources for 'Indigenous status' currently exist on the NCIS data platform - Births, Deaths and Marriages, and Coronial data derived from the police report of death (p79A)- Births Deaths and Marriages data, which may be more accurate, is a recent platform upgrade to NCIS and this data has not been backfilled for older cases. Combining the datasets, including JusticeLink, assisted in the process of attempting to overcome this data issue.

Thirdly, no databases used in this report consistently collect information around a deceased's gender identity, meaning that biological sex is privileged in existing data systems. This report includes the death of one transgender female person, who is coded on the NCIS system as 'male'. It is accordingly likely that the representation of transgender and other gender diverse people is not reflected accurately in the data contained in this report.

DATA REPORTING

Under s23 of the *Coroners Act 2009* (NSW), senior coroners are conferred jurisdiction to hold an inquest into cases where a person has died, or there is reasonable cause to suspect that the person has died while in the custody of a police officer, in other lawful custody, or while in, or temporarily absent from, a detention centre, a correctional centre, or a lock up. Under s27 of that Act, an inquest arising under s23 is considered a mandatory inquest, meaning that a coroner is required to hold an inquest in these circumstances.

This data reporting section considers, firstly, the coronial process and data relevant to the coronial investigation of First Nations people's deaths in custody, and secondly, data regarding the deaths of First Nations people who died in custody in NSW between 2008 and 2018.

CORONIAL PROCESS DATA

Between 2008 and 2018 there were 27 First Nations people who died in custody where the case has been subject to coronial investigation, with findings made and the case subsequently closed. As at January 2021, there are still 7 cases of deaths that occurred within this time period that remain open. Unless noted otherwise, data regarding the coronial process is derived from closed matters only (n = 27).

Coronial findings

Under s81 of the *Coroners Act 2009*, the coroner must record, in writing, findings as to whether the person died, and if so the person's identity, the date and place of the person's death, and the manner and cause of their death. Recommendations made pursuant to s82 must also form part of the findings in the event these are made. The issue of recommendations is specifically discussed below. Substantive issues arising from coroner's findings are also discussed below.

In 59% of findings in matters involving First Nations people's deaths in custody the finding did not indicate that the deceased was a First Nations, Indigenous, or Aboriginal person (n = 16). This may result in under-reporting of the numbers of First Nations peoples who die in custody.

In nine of the 27 cases involving First Nations people's deaths in custody the coroner's findings identified issues with the person's treatment in custody. In 11 of the 27 cases, the coroner's findings identified evidence of non-compliance with policies that were in place at the time (for instance, non-compliance with Justice Health or Corrective Services NSW policies). The most common issues identified in the inquest findings for matters examining First Nations people's deaths in custody were mental health management issues (n = 8, 30% of all inquest findings), health management issues (n = 8, 30%), issues related to prisoner dignity (n= 6, 22%), information sharing issues (n = 4, 15%) and problems with the operation of the knock up system/cell alarms (n = 4, 15%) (Fig. 1).

Figure 1: Issues identified at inquests into First Nations people's deaths in custody (n = 27)

Issue identified	Number	% of inquest findings
Mental Health Management Issues	8	30
Health Management Issues	8	30
Prisoner dignity (including use of force)	6	22
Knock up system/cell alarm operation	4	15
Information sharing issues	4	15
Safety in custody (including hanging points)	3	11
Poor risk assessment processes	3	11
Record-keeping/loss of information or evidence	3	11
Issues related to NOK	2	7
Lack of continuity of care	2	7
Lack of Aboriginal staff	2	7
Issues unrelated to custody	1	4
ALS not notified (Custody Notification System)	1	4
Racism	1	4
Treatment of Prisoners	1	4

Coronial recommendations

Under s82 of the *Coroner's Act 2009*, a coroner may make such recommendations that they consider necessary or desirable to make in relation to any matter connected with the death. The legislation gives examples of recommendations that could be made, such as recommendations around public health and safety, or recommendations that a matter be investigated or reviewed by a specified person or body. Section 82(4) outlines that the coroner is required to provide a copy of recommendations to the State Coroner, the person or body to whom the recommendation is directed, the Minister and any other Minister (if any) that administers legislation or who is responsible for the person or body to which the recommendation relates. The legislation does not require agencies/ministers to whom recommendations are directed to respond to those recommendations, although in practice[5] (as is discussed below) an initial response is mostly provided to the Attorney General's Office through the monitoring function.

Coroners made recommendations in nine of the 27 cases where First Nations people died in custody (33%), with a total of 55 recommendations being made in those cases. 53 of those recommendations were published, while 2 recommendations were subject to non-publication orders. The full text of the 53 publicly available recommendations, as well as responses to these recommendations, is contained at Annexure A of this report.

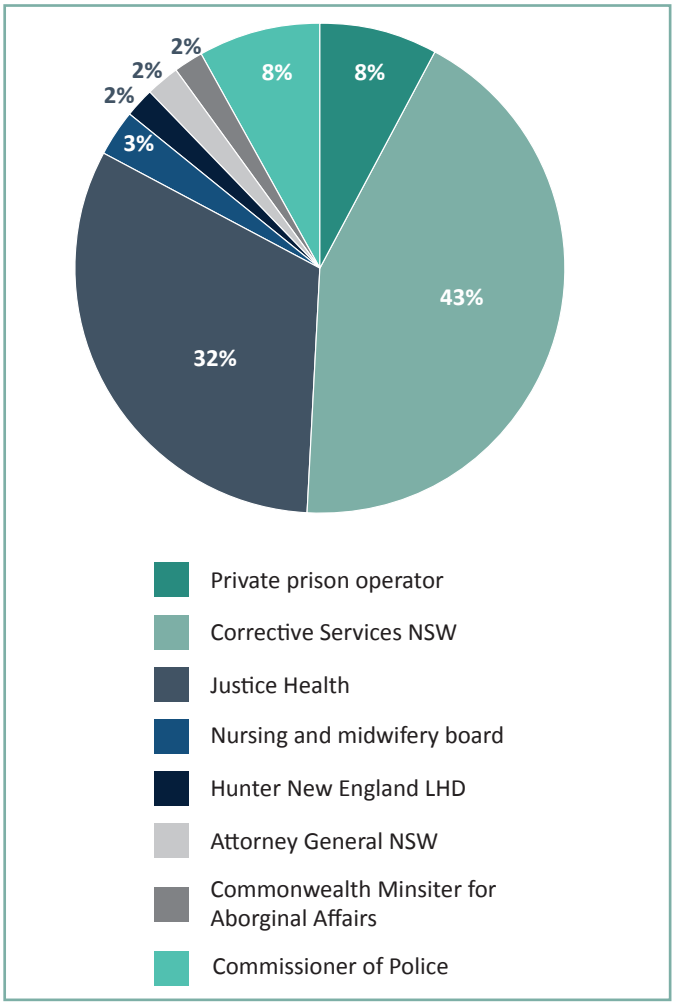
All of the nine First Nations deaths in custody that led to coronial recommendations were external cause deaths. No recommendations were made in cases where the First Nations person in custody died as a consequence of natural causes.

Recommendations by agency/ organisation

Figures 2 and 3 set out the proportion of recommendations made in matters examining First Nations people's deaths in custody by agency/organisation. While 53 publicly available recommendations were made by coroners, a number of recommendations were made to more than one agency/organisation (typically both Corrective Services NSW and Justice Health). Accordingly, the total number of recommendations in the below table exceeds 53 (amounting to 62).

The vast majority of recommendations arising from First Nations people's deaths in custody were made to Corrective Services NSW (43%) and Justice Health (32%). Other agencies/organisations subject to coronial recommendation included a private prison operator, a local health district, the NSW Attorney General, the Commonwealth Minister for Aboriginal Affairs, Commissioner of Police and the Nursing and Midwifery Board.

Figure 2: Graph of recommendations made at inquests into First Nations people's deaths in custody by agency/ organisation (n = 62)



5 In accordance with the NSW Premier's Memorandum *M2009-12 - Responding to Coronial Recommendations* (Issued 6 April 2009), at https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.

Figure 3: Table of recommendations made at inquests into First Nations people's deaths in custody by agency/organisation (n = 62)[6]

Agency/Organisation	Number of Recommendations
Private prison operator	5
Corrective Services NSW	27
Justice Health and Forensic Mental Health Network (Justice Health)	20
Hunter New England Local Health District	1
Attorney General NSW	1
Commonwealth Minister for Aboriginal Affairs	1
Commissioner of Police	5
Nursing and Midwifery Board	2
TOTAL	**62**

Recommendations by theme

Figure 4 disaggregates publicly available coronial recommendations by theme.

The most common theme for coronial recommendations following First Nations people's deaths in custody was improving mental health treatment (n = 13), followed by additional training related to the management of healthcare issues in custody (n = 8) and improved medical care for inmates (n = 6),. It was common for coroners to recommend that agencies/organisations conduct policy compliance audits (n = 6), and for coroners to make miscellaneous recommendations relating to prisoner safety (n = 5). A number of recommendations related specifically to First Nations persons in custody, with three recommendations relating to Aboriginal staffing levels, and two relating to custody notifications for Aboriginal persons in custodial settings.

Recommendation Implementation

Coronial recommendations and responses to such recommendations are contained in tables, published on the NSW Justice website[7] by year and deceased name. Due to resourcing limitations, tables are updated six monthly, but after an initial request for a response is issued, this is routinely not followed up unless there is a specific request from a minister or coroner to do so.[8] Recommendations that are subject to a non-publication order are communicated to the relevant agency/person in line with legislation, but are not subsequently monitored by Justice. As noted previously, there is no legislatively mandated response or monitoring requirement for coronial recommendations in NSW.

The following data is derived from the publicly available monitoring information on the NSW Justice website[9]. In undertaking this analysis, regard has been made to the actions indicated by the response to the recommendation, rather than the status of the response as indicated by the agency/organisation. Accordingly, even where the agency/organisation may indicate that the action has been completed, this will not be marked as 'fully implemented' unless the text of the monitoring response supports that this is the case. There has been no action to verify the implementation of recommendations beyond the text provided in the monitoring response, so it is also possible that implementation statistics may be an undercount where action has subsequently been undertaken, but the monitoring table has not been updated on the website.[10]

Review of the monitoring information indicates that the majority of coronial recommendations made following First Nations people's deaths in custody have been supported (n = 30), and only four recommendations have not been supported. Of those that were not supported three recommendations related to the use of force in prisons and a policy audit of same, and one recommendation related to improving mental health treatment for inmates.

For almost a third of recommendations made in coronial inquests into First Nations people's deaths in custody, no response has been received as at February 2021. The outstanding responses relate to recommendations made in inquests in February

6 Recommendations to Justice Health include two recommendations to the Minister for Health which related to Justice Health.
7 At https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx
8 Personal Communication, NSW Justice employee, 2021.
9 As at February 2021 and as reflected in the recommendation and Response table at Annexure A.
10 See, for example, the updating implementation information relating to the death of Rebecca Maher in Annexure A at pg. 43.

2020, May 2020 and November 2019. For a further two recommendations a response was received but the agency's position on the recommendation was unclear.

Over a quarter of the recommendations have been partially implemented, and over a quarter have been fully implemented. Few recommendations have been supported without any action to implement (n = 2).

Of the three recommendations relating to Aboriginal staffing, two received no response and while the other was supported, no action to implement this recommendation is described in the monitoring table. Of the two recommendations relating to Aboriginal Legal Services custody notifications, the response set out in the table does not indicate either support or action to implement as at February 2021 (Fig. 5).

Figure 4: Recommendations made at inquests into First Nations people's deaths in custody by primary recommendation theme (n = 59)

Primary Recommendation Theme	Number of Recommendations
Improved mental health treatment	13
Additional training related to healthcare issues in custody	8
Policy compliance audit	6
Improved medical care	6
Prisoner safety (miscellaneous)	5
Additional training related to management of prisoners	4
Reduce/evaluate uses of force in custodial settings	3
Improved Aboriginal staffing	3
Professional conduct referral	2
Improved information sharing between agencies	2
Removing hanging points	2
Improved record-keeping	2
Aboriginal Legal Services Custody notifications	2
Improved engagement with families	1
TOTAL	**59**[11]

Figure 5: Implementation of recommendations made at inquests into First Nations people's deaths in custody (n = 53)

Implementation status	Number of Recommendations	% of Recommendations
No response received	17	32
Supported, partially implemented	15	28
Fully implemented	13	25
Supported, not implemented	2	4
Not supported	4	8
Response does not indicate support or implementation	2	4
TOTAL	**53**	**101**[12]

11 Six cases involved two primary themes.

12 This number exceeds 100% due to rounding.

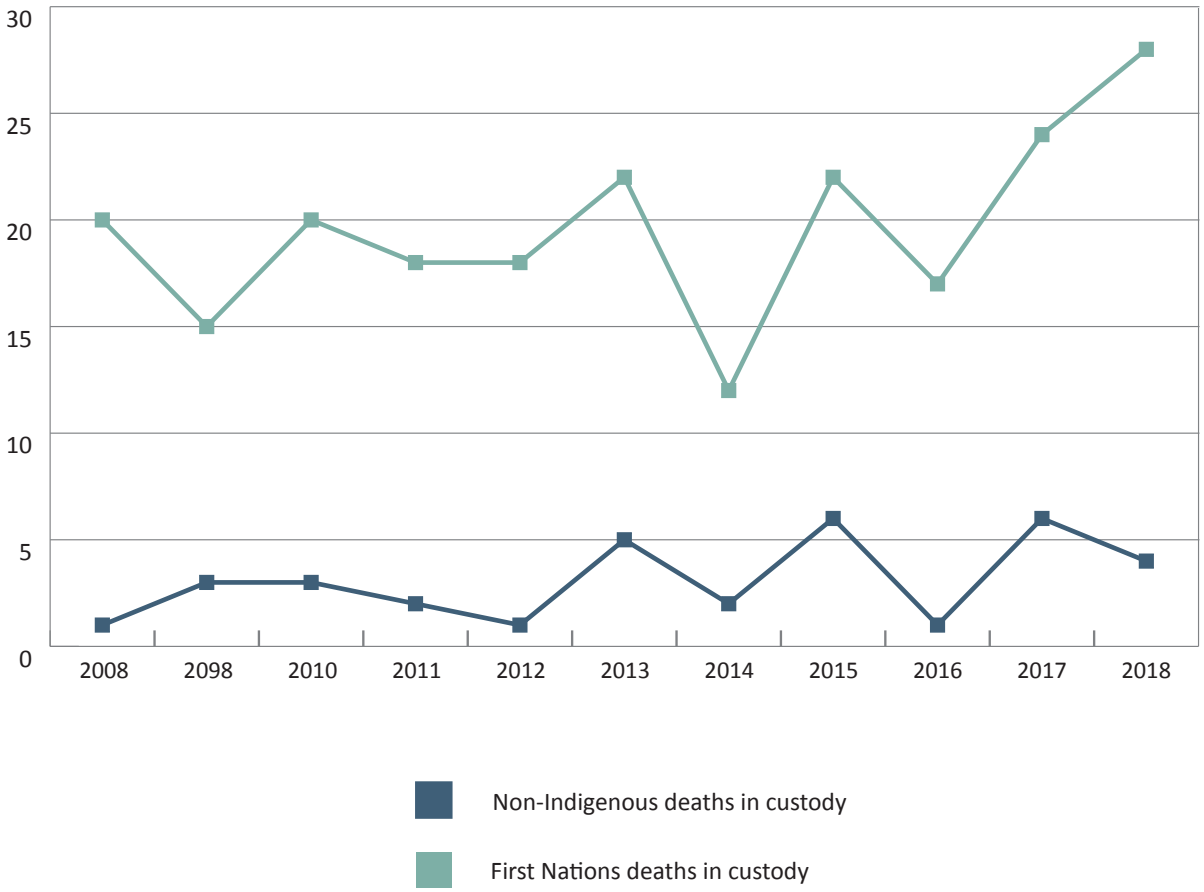
First Nations Deaths in Custody Data

This section presents data concerning the characteristics of First Nations people's deaths in custody occurring between 2008 and 2018.

Overview of All Deaths in Custody in NSW

Between 1 January 2008 and 31 December 2018 there were 250 deaths in custody in NSW. This number includes the deaths of 238 males, 11 females and one transgender woman.[13] During this time period, First Nations people accounted for 13.6% of the deaths in custody(n = 34); including the deaths of 31 Aboriginal identifying males, two Aboriginal identifying females, and one Aboriginal identifying transgender female person. 216 non-Indigenous people died in custody during the same period, including the deaths of 207 males, and 9 females (Fig. 6, Fig.7).

Figure 6: NSW deaths in custody by Indigenous status by year (n = 250)



13 The gender identity of the female identifying transgender person was identified through review of the findings and the coronial brief. It is likely that the representation of transgender and gender diverse people in this dataset is an underestimation of true prevalence given that the data systems utilised for the study do not support the accurate collation of this data.

Figure 7: Table of NSW deaths in custody by Indigenous status by year (n = 250)

Year	Total deaths in custody in NSW	First Nations people's deaths in custody in NSW	Non-Indigenous people's deaths in custody in NSW
2008	21	1	20
2009	18	3	15
2010	23	3	20
2011	20	2	18
2012	19	1	18
2013	27	5	22
2014	14	2	12
2015	28	6	22
2016	18	1	17
2017	30	6	24
2018	32	4	28
TOTAL	**250**	**34**	**216**

While the majority of the 250 deaths in custody were a consequence of natural causes (n = 149, 60%), the proportion of First Nations people who died due to external causes was slightly higher than the proportion of non-Indigenous people who died due to external causes (44% for First Nations people compared with 39% for non-Indigenous people) (Fig. 8).

Figure 8: NSW deaths in custody by External/Natural cause of death and Indigenous status (n = 250)

Cause of Death	First Nations people's deaths in custody in NSW	% of total First Nations people's deaths in custody	Non-Indigenous people's deaths in custody in NSW	% of total non-Indigenous people's deaths in custody	All deaths in custody in NSW	% of all deaths in custody in NSW
External Causes	15	44%	84	39%	99	40%
Natural Causes	19	56%	130	60%	149	60%
Unascertained	0	0%	2	1%	2	1%
TOTAL	**34**	**100%**	**216**	**100%**	**250**	**101%**[14]

The proportion of deaths in custody attributed to intentional self-harm was similar for First Nations people and non-Indigenous people. Intentional self-harm deaths accounted for 29% of First Nations people's deaths in custody, and 27% of non-Indigenous people's deaths in custody (Fig. 9).

14 This number exceeds 100% due to rounding.

Figure 9: NSW deaths in custody by manner of death by Indigenous status (n = 250)

Manner of Death	Number of First Nations people's deaths in custody	Number of non-Indigenous people's deaths in custody
Natural Causes	19	130
External Causes-Assault	1	8
External Causes-Accident	0	7
External Causes-Accidental overdose	3	8
External Causes-Multi	1	2
External Causes-Intentional self-harm	10	59
Unascertained	0	2
TOTAL	**34**	**84**

Between 2008 and 2018 First Nations people who died in custody were dying at a younger age compared to non-Indigenous people who died in custody. The average age of non-Indigenous people who died in custody in NSW was 52 years, while the average age of First Nations people who died in custody in NSW was 41 years.

Overview of s23 First Nations people's deaths in custody

This section provides data around the characteristics of First Nations people's deaths in custody that occurred in NSW between 2008 and 2018 (n = 34). This section includes data derived from all cases during this time period (both open and closed cases) unless otherwise indicated.

Sex/Gender of deceased

91% of the First Nations people who died in custody were male (n = 31), 6% were female (n = 2) and one person identified as a transgender woman (3%).

Age

The average age of First Nations people who died in custody was 41 years old. The youngest First Nations person who died in custody was 19, and the oldest was 86 years old. This data is disaggregated by external and natural cause deaths in the following section.

Manner of Death

56% of the First Nations people who died in custody died due to natural causes (n = 19), and 44% died in custody due to external causes (n = 15).

Legal status

The majority of First Nations people who died in custody were sentenced prisoners (n = 20, 59%), while 10 First Nations people who died in custody were on remand (29%), three First Nations people who died in custody were both sentenced prisoners and on remand in relation to other charges (9%) and one First Nations person who died in custody was in other lawful custody (3%) (Fig. 10).

Figure 10: Legal status of First Nations people who died in custody (n = 34)

Legal Status	Number of prisoners
Remand	10
Sentenced	20
Both	3
In other lawful custody	1
TOTAL	**34**

Facility where the death occurred

31 of the First Nations people who died in custody died in the custody of government-run prisons. Three of the First Nations people who died in custody died in the custody of privately-run prisons.

Length of incarceration period prior to death

The shortest period a First Nations person who died in custody was incarcerated prior to their death was less than 24 hours, and the longest period was 25.5 years. Over half of the First Nations people who died in custody had been incarcerated for less than 12 months (N=18, 53%).

Length of incarceration is presented by external/natural cause deaths in the below sections.

Prisoner movement

Many of the First Nations people who died in custody moved correctional facilities multiple times during the period of incarceration in which they died. On average, First Nations people were incarcerated in four different custodial facilities (excluding police cells) during the custodial period in which they died. The highest number of correctional facilities a First Nations person moved between during their custodial period was eight facilities, and the lowest number was one.

External cause deaths overview

As noted above, 44% of the First Nations people who died in custody died due to external causes (n = 15). The two First Nations women who died in custody and the First Nations transgender female person who died in custody, died due to external causes.

The average age of First Nations people who died due to external causes was 30 years old. The youngest First Nations person who died due to external causes was 19 years old, and the oldest person who died of external causes was 36 years old.

The most common external cause deaths of First Nations people in custody were deaths due to intentional self-harm (n = 10). First Nations people also died as a consequence of accidental drug overdoses (n = 3), assault (n = 1) and multiple causes (n = 1) (Fig. 11).

Figure 11: Manner of death of First Nations people who died in custody (n = 34)

Manner of Death	Number of deaths
Natural Causes	19
External Causes- Assault	1
External Causes- Accident	0
External Causes- Accidental overdose	3
External Causes- Multi	1
External Causes- Intentional self-harm	10
Unascertained	0
Total	**34**

The most common method of intentional self-harm was hanging (n = 9, 90%) and one person died as a consequence of intentional self-harm arising from asphyxiation (other) (n = 1, 10%).
The majority of First Nations people who died in custody due to intentional self-harm were on remand at the time of their death (n = 8, 80%). Most of these deaths occurred at the Metropolitan Remand and Reception Centre in Sydney (n = 5, 60%).

Of the 10 First Nations people who died in custody due to intentional self-harm, four had been incarcerated for one month or less (including two cases where the person had been in custody for 5 days or less). The longest period that a person had been incarcerated prior to dying due to intentional self-harm was 23 months.

All of the First Nations people who died in custody due to intentional self-harm had a prior history of mental health issues. Half of the First Nations people who died due to intentional self-harm in custody had previously attempted suicide while in custody (n = 5).

Natural Cause Deaths overview

As noted above, 56% of the First Nations people who died in custody died due to natural causes (n = 19).

The average age of First Nations people who died in custody due to natural causes was 49 years old. The youngest First Nations person who died of natural causes was 31 years old, and the oldest person who died of natural causes was 86 years old.

The shortest period a First Nations person was in custody prior to dying from natural causes was 5 days, and the longest period was 25.5 years. Most First Nations people who died in custody from natural causes had been incarcerated for less than 3 years at the time of their death (n = 12).

The most common type of natural cause deaths for First Nations people who died in custody were deaths due to cardiac arrest (n = 3), deaths due to ischaemic heart disease (n = 3), deaths due to cancer (n = 3), deaths due to cerebrovascular disease (n = 2) and deaths due to atherosclerosis (n = 2).

Heart conditions and/or heart disease accounted for half of the 19 natural cause deaths of First Nations people in custody (n = 10) (Fig. 12).

Figure 12: Natural causes of death for First Nations people who died in custody by underlying cause (n = 19)

Natural cause death by underlying cause	Number of deaths
Septicaemia	1
Cancer	3
Ischaemic heart disease	3
Cardiomyopathy	1
Cardiac Arrest	3
Cardiac arrhythmia	1
Cerebrovascular disease	2
Atherosclerosis	2
Acute respiratory disease	1
Ill-defined condition	1
Multi	1
Total	**19**

Broader data capture

Prior contact with the criminal justice system

One of the key findings of the Royal Commission into Aboriginal Deaths in Custody was the disproportionate contact that First Nations people have with the criminal justice system, frequently for minor offences and from a young age. Similar findings were identified from review of coronial cases of First Nations people's deaths in custody that occurred in NSW between 2008 and 2018.

Initial contact with the criminal justice system

For the majority of s23 First Nations people's deaths in custody, extensive information around the deceased's criminal history was available on the brief of evidence or via JusticeLink.[15] This information highlighted that almost four-fifths (84%) of the First Nations people who died in custody were known to the criminal justice system before the age of 18 years (n = 26). In almost half of these cases, the First Nations person who died in custody was known to the criminal justice system before they were 15 years of age (n = 12) and the youngest a First Nations person who died in custody became known to the criminal justice system was 10 years of age.

Criminal histories[16]

The most common offences that First Nations people who died in custody had previously been charged with were acts intended to cause injury, such as assault (n = 31, 91%); offences against government procedures, government security and government operations, for example breaching bonds (n = 22, 65%); and public order offences (n = 21, 62%) (Fig. 13).

Incarceration histories

For 30 of the s23 First Nations people's deaths in custody information was available about the age at which the deceased was first incarcerated. For these deceased people the youngest age the deceased was incarcerated was 12 years, and the oldest age a deceased person was first incarcerated was 83 years old. 60% of the First Nations people who died in custody had been first incarcerated at or before 18 years of age (n = 18).[17]

Most of the First Nations people who died in custody had been previously incarcerated (before the period of incarceration in which they died).[18] Five of the deceased persons died during their first period of incarceration, and 29 of the deceased persons had been incarcerated on at least one occasion before the period of incarceration during which they died. First Nations people who died in custody had previously been in custody in NSW on an average of six prior occasions.[19] One deceased First Nations person had previously been incarcerated on 38 occasions (the person died while serving their 39th period in custody).

15 For 31 of the 34 First Nations people who died in custody comprehensive information about the deceased person's contact with the criminal justice system was available from the brief of evidence or JusticeLink.

16 This section presents data around previous charges, rather than previous convictions. Information was not always available around the progression of charges to conviction. Some deceased persons may have been charged with offences within a particular category multiple times but is only counted in each category once (as the data is calculated per person).

17 As juvenile detention records were not typically included on the brief of evidence or accessible to the researchers via justice systems, it is likely that some deceased people had juvenile detention histories that have not been taken into account in this analysis. This information was mostly ascertained from the histories the deceased person gave to Corrective Services NSW and/or the evidence of family and friends.

18 This includes periods of incarceration in custodial facilities and/or remand centers, it excludes police custody.

19 This is likely an underestimation due to a lack of information around juvenile detention on some of the briefs of evidence/JusticeLink, and a lack of records in relation to criminal offending histories/incarceration periods in other states or territories.

Figure 13: Charge history for First Nations people who died in custody (n = 34)[20]

Prior charge data	Number of deceased persons who were charged with offence type	% of deceased persons who were charged with offence type
1- Homicide and related offences	5	15%
2- Acts intended to cause injury	31	91%
3- Sexual assault and related offences	12	35%
4- Dangerous or negligent acts endangering persons	0	0%
5- Abduction, harassment and other offences against the person	13	38%
6- Robbery, extortion and related offences	11	32%
7- Unlawful entry w/i, burglary, b&e	19	56%
8- Theft and related offences	17	50%
9- Fraud, deception and related offences	4	12%
10- Illicit drug offences	13	38%
11- Prohibited and regulated weapons and explosives offences	9	26%
12- Property damage and environmental pollution	17	50%
13- Public order offences	21	62%
14- Traffic and vehicle regulatory offences	18	53%
15- Offences against government procedures, government security and government operations	22	65%
16- Other	5	15%

Mental health

For 79% of the First Nations people who died in custody there was evidence that the deceased had a history of mental health issues when they died (n = 27). As noted previously, the adequacy of mental health treatment for First Nations people in custody has been previously identified in a high proportion of coronial cases, and was a common topic for coronial recommendations.

Alcohol and other drug use

For over 76% of the First Nations people who died in custody there was evidence that the deceased had issues with alcohol and/or other drug use at the time of, or proximal to, their death (n = 26).[21]

Other data

While intergenerational trauma was identified as a characteristic in a number of cases, this was unable to be quantified for the study based on the available information. Similarly, while it was identified that child removal, both of the deceased and the deceased's children, was a characteristic in a number of cases, this was unable to be quantified on the available information.

20 Offences coded in accordance with the Australian and New Zealand Standard Offence Classification, see https://www.abs.gov.au/ausstats/abs@.nsf/mf/1234.0).

21 In four cases this information was unable to be ascertained from the information available on the brief of evidence.

02.

ANNEXURE A: RECOMMENDATIONS AND RESPONSES

This Annexure sets out the 53 publicly available recommendations made by Coroners in cases where First Nations people died in custody together with the responses to these recommendations, as reflected on the NSW Justice website as at February 2021.[22]

22 https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx, accessed 20 February 2021.

Inquest into the death of Jonathan Hogan (2020)

Recommendation

1. Review the Junee CC's practice and procedures at the intake stage to ensure that inmates with known diagnoses for serious mental illnesses (e.g. schizophrenia) are reviewed by a suitably qualified mental health clinician in a timely manner for the purposes of:
   a. assessing the inmate's condition.
   b. consulting with other clinicians (if necessary) and to make recommendations about treatment (including whether the inmate requires antipsychotic medication)
   c. documenting what the inmate's risks are and how those risks are to be managed assuming the inmate is placed within the general population (including the possibility of "two-out" cell placements).
2. Examine the current ratio of mental health treating staff, to inmates requiring mental health reviews and treatment, and whether the staffing ratios and resources are sufficient to ensure:
   a. inmates who are suffering serious mental illnesses are reviewed by a suitably qualified mental health clinician in a timely manner after entering the Junee CC.
   b. inmates who are suffering serious mental illnesses thereafter are reviewed by a psychiatrist or by another suitability qualified mental health clinician at reasonable intervals having regard to the severity of their illness, circumstances and the potential changeability of their condition.
   c. mental health clinicians carrying out patient reviews are afforded a reasonable opportunity to review an inmate's patient file and other collaborative sources.
3. In consultation with Justice Health, review the Junee CC's practice and procedures as regards the provision of antipsychotic medication to ensure, in the event an inmate misses taking their daily antipsychotic medication, the mental health treating team is notified of this fact and the inmate reviewed about this issue in a timely manner (specifically taking into account the opinion expressed by Dr Kerri Eagle in these proceedings about the impact of an inmate missing Olanzapine medication).
4. Consider creating at least three full-time equivalent Aboriginal Health Worker positions based at the Junee CC, at least one of whom has responsibility for the provision of mental health care and treatment to Aboriginal inmates.

Agency/Organisation

The Chief Executive Officer, GEO Group Australia Pty Ltd

Response recorded as at February 2021

No response

Recommendation

5. GEO Group in consultation with Corrective Services NSW ("CSNSW") urgently examines replacing or altering the bed frames of the kind used within the B2 Unit at Junee CC on 3 February 2018 to remove possible hanging points.

Agency/Organisation
The Chief Executive Officer, GEO Group Australia Pty Ltd and the Commissioner of Corrective Services NSW
Response recorded as at February 2021
No response
Recommendation
6. CSNSW, in consultation with other stakeholders, examine the utility of adapting the telephone system available for inmate use to include an alert system when inmates make a significant number of calls to a particular number in a short period.
Agency/Organisation
The Commissioner of Corrective Services NSW
Response recorded as at February 2021
No response

Inquest into the death of Tane Chatfield (2020)

Recommendation

1. That Corrective Services NSW ("CSNSW") conduct a comprehensive audit of all cell hanging points at the Tamworth Correctional Centre and undertake urgent removal of any hanging points identified.
2. That CSNSW amend policy to notify the next of kin if an inmate is taken to a hospital in a medical emergency, even if that inmate is not ultimately admitted.
3. That CSNSW implement a policy whereby prisoners who have been taken to hospital are not returned to prison without a discharge summary.
4. That CSNSW, in consultation with Justice Health and Forensic Mental Health Network ("Justice Health"), adopt a policy whereby any inmate who has been taken to Hospital is placed either two out or in an assessment cell until a comprehensive Justice Health review can take place. In the event that this is not considered suitable or appropriate, any other placement must be documented with reasons recorded.
5. That CSNSW and Justice Health actively recruit Aboriginal health workers at Tamworth Correctional Centre. The provision of Aboriginal health workers must include consideration of expanded culturally appropriate Drug and Alcohol and Mental Health Services and workers with expertise in suicide prevention strategies.
6. That Hunter New England Local Health District provide a copy of a discharge summary to officer escorts when a custodial patient is discharged from a Hunter New England health service (including from the Emergency Department).
7. Pursuant to s. 151A(2) of the Health Practitioner Regulation National Law no 86a, the transcript of the evidence of Ms Adams be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Ms Adams on 20 September 2017 should be the subject of review.

Agency/Organisation

Commissioner of Corrective Services
Commissioner of Corrective Services and Justice Health and Forensic Mental Health Network
Hunter New England Local Health District
Chief Executive, Nursing and Midwifery Board of Australia

Response recorded as at February 2021

No response

Inquest into the death of LP (2020)

Recommendation
1- I recommend that consideration be given to the implementation or variation of relevant Local Operating Procedures at the Metropolitan Remand and Reception Centre to provide that (a) the interval for review of inmates subject to a Risk Intervention Team Management Plan and/or housed in an assessment cell is to be no longer than 24 hours; and (b) where a review of an inmate cannot be completed such a review is to be deferred to the following day, with priority to be given to review of the inmate on that subsequent day. 2- I recommend that consideration be given to amending section 5.3 of the Custodial Operations Policy and Procedures to provide guidance to Risk Intervention Team (RIT) members as to what is to occur if a RIT assessment review is unable to be completed due to an inmate's emotional state, level of aggression, or intoxication due to alcohol or drug use and, as a result, the RIT is unable to determine whether a RIT Discharge Plan is to be completed or a RIT Management Plan is to be developed.
Agency/Organisation
The Commissioner of CSNSW
Response recorded as at February 2021
No response
Recommendation
3- I recommend that consideration be given to the circumstances of the death of LP being used as a case study as part of training and education provided to CSNSW and Justice Health staff to raise awareness regarding the possible risks of self-harm associated with the use of plastic packaging from meal packs (with appropriate anonymization, and conditional upon consent being provided by LP's family and following appropriate consultation with them).
Agency/Organisation
The Commissioner of CSNSW and the Chief Executive Officer, Justice Health & Forensic Mental Health Network
Response recorded as at February 2021
No response

Inquest into the death of David Dungay (2019)

Recommendation

1. That training on the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital (January 2019) and Enforced Medications- Long Bay Hospital Mental Health Unit (January 2019) be provided to all CSNSW and Justice Health staff working at Long Bay Hospital, including theory, practical training and assessment.
2. That CSNSW and Justice Health audit compliance with the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital and Enforced Medications- Long Bay Hospital Mental Health Unit Local Operating Procedures.
3. That Section 4.6 of the Enforced Medications- Long Bay Hospital Mental Health Unit (January 2019) be amended to mandate the attendance of a psychiatrist/medical officer to assess a patient in the event of administration of enforced medication.
4. That the Joint Planned Medication Checklist of the Enforced Medications- Long Bay Hospital Mental Health Unit (January 2019) be amended to include information indicating that risk factors for restraint and positional asphyxia have been considered by Justice Health and CSNSW staff prior to the administration of enforced medications.
5. That the Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital (January 2019) and Enforced Medications- Long Bay Hospital Mental Health Unit (January 2019) be amended to provide that Justice Health medical personnel are able to give directions to CSNSW correctional officers regarding the positioning of a patient for the administration of injections.

Agency/Organisation

Commissioner, Corrective Services New South Wales and Chief Executive, Justice Health & Forensic Mental Health Network

Response recorded as at February 2021

Recommendation 1 – Completed

A two-day package was developed by SOG, due for rollout in early 2020, and is for CSNSW and JH&FMHN staff at LBH.

As of September 2020, JH&FMHN has implemented a training plan to ensure the clinical competency of staff to adhere to Network specific policies and procedures in relation to medication administration prior to, during, and following the administration of enforced medication. CSNSW staff have also participated in, and will continue to engage in, these training programs.

The training sessions provided to staff include, simulation-based training in the mental health unit at LBH and the code blue session plans with training in communication for emergency situations and emergency sedation simulations.

Every Network staff member at LBH has now completed a clinical competency assessment to assess their skills, knowledge, values and abilities in the administration of enforced medication and joint planned interventions with CSNSW. This is to ensure staff are providing safe and effective care in line with Network specific policies and protocols.

Recommendation 2 – Completed

JH&FMHN have developed an audit tool via the Quality Audit Reporting System (OARS) to monitor compliance with the *Enforced Medications - Long Bay Hospital Mental Health Unit Local Operating Procedure*. This state-wide system is utilised to improve the provision of high quality and safe health care.

JH&FMHN's OARS audit tool was endorsed by the JH&FMHN and CSNSW in August 2020.

Recommendation 3 – Completed

JH&FMHN has amended section 4.6 of the *Enforced Medications - Long Bay Hospital Mental Health Unit* local operating procedure to mandate the attendance of a psychiatrist or medical officer to assess a patient in the event of administering enforced medication. The following direction is now published in the procedure, "the Psychiatrist/ Medical Officer MUST attend the ward and assesses the patient and the need for enforced medication".

This document is intended to provide guidance to staff on Network specific policies and procedures in relation to medication administration prior to, during, and following the administration of enforced medication.

Recommendation 4 – Completed

The *Joint Planned Intervention Checklist* attached at appendix 10 of the Enforced Medications- *Long Bay Hospital Mental Health Unit* local operating procedure has been amended to include a medical alert. The medical alert confirms that the JH&FMHN and CSNSW staff have considered the below risk factors for restraint prior to the administration of enforced medications:

- Cardiovascular
- Respiratory (e.g. asthma)
- Diabetes
- Neurological
- Disability (e.g. developmental, speech, hearing)
- Trauma
- Obesity
- Pregnancy.

Recommendation 5 – Completed

The JH&FMHN has amended the following local

operating procedures and checklist to inform Network medical personnel that they are able to give instruction to CSNSW officers regarding the position of a patient for the administration of injections:

- The Enforced Medications- Long Bay Hospital Mental Health Unit;
- Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital; and
- Joint Planned Intervention Checklist.

Recommendation

6. That all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.
7. That Corrective Services New South Wales review the use of the proclamation process by the Immediate Action Teams in Long Bay Hospital to ensure that appropriate consideration is given, at the time the proclamation issued, to the possibility that a mentally ill inmate patient may not be in a position to comply or respond to the proclamation in a rational manner.
8. That CSNSW continue to provide Positional Asphyxia Awareness online training to all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent, and audit completion rates annually to identify correctional staff who have not yet completed such training.
9. That CSNSW continue to provide specialist practical training on positional asphyxia to Immediate Action Team and Special Operations Group officers, and audit completion rates annually to identify officers who have not yet completed such training.

10. That CSNSW provide training to all Corrective Services Officers working in the Mental Health Unit in restraint techniques, positional asphyxia and the risks of sudden death from restraint.
11. That CSNSW audit at least one-third of all video recordings, as a representative sample, of uses of force by Immediate Action Teams in order to verify that sections 13.7.8 and 13.7.9 of the Custodial Operations Policy and Procedures have been complied with, with consideration to be given to additional auditing if the nominated representative sample does not allow for such verification.
12. That CSNSW complete the trial of a suitable soft restraint system for use in the Mental Health Unit as an alternative to the use of handcuffs, with the relevant training to be provided to applicable staff including staff in G Ward.
13. That CSNSW, through the Special Operations Group, create and implement a revised use of force training package for Mental Health Unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.
14. That CSNSW review the current version of the Custodial Operations Policy and Procedure to ensure that clear instructions are provided requiring the retention of all potentially relevant video footage, including CCTV footage, in the event of a death in custody

Agency/Organisation

Commissioner, Corrective Services New South Wales

Response recorded as at February 2021

Recommendation 6.

Corrective Services NSW has 24 identified ATSI Offender Services and Programs roles in total (1 Senior Service and Programs Officer [Clerk 7 /8] and 23 Service and Programs Officers [Clerk 5/61). Specifically, there is currently one Service and Programs Officer [Clerk 5/6] role at Long Bay Hospital available during business hours, which can be utilised for these purposes. The Governor of the Long Bay Hospital will remind staff to contact this role as required. Due to the role and function of Long Bay Hospital is not feasible to embed an Aboriginal Inmate Delegate within the Mental Health Unit.

Recommendation 7 – Not supported

It is current policy for CSNSW staff to issue a verbal proclamation prior to a planned use of force. Whilst appropriate consideration is given to the mental health of the relevant inmate prior to commencing planned use of force in Long Bay Hospital, CSNSW Officers, including IAT Officers, are not trained mental health professionals and do not possess the professional skills needed to determine whether an inmate is intentionally being non-compliant or is not in a position to comply in a rational manner. It is also noteworthy that often use of force is required to protect both the mentally ill inmates themselves (from self-harm) and for the safety, protection and security of staff, including JH staff. CSNSW will continue to encourage Officers to consider the mental capacity of inmates to rationally respond to the proclamation.

Recommendation 8 – Completed

Online training has been developed for custodial staff and is auditable.

Recommendation 9 – Completed

Training now includes training on positional asphyxia to IAT and SOG provide specialist practical training on staff. This training is auditable. Over 400 IAT and SOG staff members have already been provided specialist positional asphyxia training since it was rolled out. The SOG IAT Senior Assistant Superintendent (SAS) will undertake yearly audits of training completion by IAT staff members and identify staff yet to complete training.

Recommendation 10 – Completed

Mandatory e-learning- Positional Asphyxia Awareness was implemented in July 2018. Training to all correctional staff is conducted via LMS on positional asphyxia. A joint AC Custodial Corrections and AC Security and Intelligence Memorandum was released to all staff on 31/07/2018 instructing staff to complete the mandatory course and to identify updated Custodial Corrections Policy and Procedures (COPP)- Section 13.7 Use of Force, which was updated to include information on position.ii asphyxia. All custodial staff are trained in the use of restraints during primary training.

Recommendation 11 – Not supported

All incidents of use of force are reviewed by CSNSW. Tier 1 incidents are reviewed by the relevant governors In the first instances and are then referred to the Tier 1 Use of Force Committee, as outlined in COPP section 13. 7 Use of force. The Operational Performance and Review Branch audit a random sample of up to 10% of Tier 2 incidents. CSNSW recently reviewed the policy and procedures relating to use of force in response to a separate matter at ICAC.

There are a large volume of incidents relating to use of force within the CSNSW system. With currently available resources and funding levels, it is not practically possible to audit one third of all video recordings of uses of force by Immediate Action Teams.

Recommendation 12 – In progress

The 6 month trial of soft restraints at the Surry Hills Court Cells, Amber Laurel Correctional Centre, Silverwater Women's Correctional Centre, Long Bay Hospital and Metropolitan Special Programs Centre has commenced in January 2020 and is working well so far.

Recommendation 13 – Not supported

Use of force training is provided as part of primary training and encapsulates a large amount of technical skills with specific training requirements to meet tertiary education qualification standards. The training occurs over 11 days and includes training and assessing competence in using firearms, batons, defensive tactics, restraints, riot response, de-escalation and communication techniques, as well as exposure to CS gas. All Correctional Officer staff undertakes this training prior to being posted to a work location (i.e. Correctional Centre or Court Cells.

The Security Operations Group (SOG) provides supplementary courses for staff v1hc occupy roles in Immediate Action Teams (IAT), the Medical Escort Unit (MEU) and mental health units. This training is additional to primary training on use of force and includes (depending on the course) use of force refresher training, positional asphyxia training, managing non-compliance, use of chemical munitions, developing Local Operating Procedures (LOPs) and will soon include soft restraint training.

All of these training programs include training in de-escalation techniques and communication skills, both specific theory, and application through scenario training.

When complemented by ancillary training provided by Brush Farm Corrective Services Academy (BFCSA), including Managing at risk inmates, managing female inmates, managing .young adult offenders, mental health awareness, safe management, trauma informed practice, working with AOD offenders and mental health first aid, a more complete training profile is created and courses are facilitated by the staff most qualified to do so.

Given the breadth of topics that need to be covered in use of force training, it is not feasible to spend 50% of the training time on de-escalation techniques. However, along with the supplementary and ancillary courses, and Correctional Centre Governors implementing regular local training days, a strong multi-disciplinary training profile is available, to provide sound training to staff working in mental health units, which includes a continued theme of de-escalation and communication skills throughout all components.

Recommendation 14 – Completed

The COPP will be reviewed and any necessary amendments incorporated. At this stage, it is anticipated that the review process, including initial drafting, consultation and further amendments, and approval, will be completed in the first quarter of 2020. Relevant staff from Custodial Corrections and Security & Intelligence will meet to review progress.

COPP section 13.9- Video evidence includes within subsection [4.6] the requirements for retention and disposal of records in accordance with the Functional Retention ond Disposal Authority: DA199. It states that recordings with evidentiary value of significant incidents, such as a death in custody, including coronial investigations and reports, must be retained for 25 years and then sent to State Archives

Recommendation

15. That Justice Health implement training for all clinical staff working at Long Bay Hospital Mental Health Unit, including medical officers, in relation to the NSW Heath Policy Directive Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales (PD2012_035).
16. That Justice Health give consideration to whether a position other than the prone position should be utilised for enforced medication to be administered under the Enforced Medication and Rapid Tranquilisation- The Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.180) and emergency sedation to be administered under the Emergency Sedation – Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.441).
17. That Justice Health amend the Medical Emergency Response procedure and training/educational materials in respect of the Procedure to include a statement to the effect that it is the responsibility of the Medical Emergency Response Team Leader to assign roles to team members in the event of a Medical Emergency Response and to oversee and direct the Response, but not to actively participate in it.
18. That Justice Health amend the Medical Emergency Response Procedure and training/educational materials in respect of the Procedure to include specific reference to the roles which the Medical Emergency Response Procedure Team Leader is to assign to Response participants.
19. That Justice Health audit staff performance under the Medical Emergency Response Procedure and the Medical Emergency Response Procedure Checklist to ensure compliance.

Agency/Organisation

Chief Executive, Justice Health & Forensic Mental Health Network

Response recorded as at February 2021

Recommendation 15 – In progress

To support this recommendation, the Justice Health Forensic Mental Health Network implemented a violence prevention and management education plan for all clinical staff at the mental health unit at Long Bay Hospital in August 2019.

As at July 2020, 90% of mental health unit staff at Long Bay Hospital have received training, which is aimed to complement the Corrective Services NSW security roles. The completion of training will continue to be monitored through the Justice Health and Forensic Mental Health Network Close the Loop Committee.

This training also supports the NSW Health state wide policy directives PD2020_004 Seclusion and Restraint in NSW Health Settings and PD2017_008 Violence Prevention and Management Training Framework for NSW Health Organisations. The Health Education & Training Institute also provides face to face workshops for team restraint techniques for NSW Health staff who are responsible for assessing, caring for, treating, case managing or providing other services to forensic and/or correctional patients; and/or staff who work in mental health facilities.

Recommendation 16 – Completed

The Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital local operating procedure has been revised to include a direction to staff to consider patient positioning during enforced medication or rapid tranquilisation. As outlined in the response to recommendation 4, the Joint Planned Intervention Checklist now includes a medical alert for risk factors to be considered by Justice Health Forensic Mental Health Network and Corrective Services NSW staff prior to restraint and the administration of enforced medications.

Recommendation 17 & 18 – Completed

The Clinical Procedure Long Bay Hospital- Clinical Emergency Response and Medical Emergency Team now includes specific information on the roles which the Medical Emergency Team (MET) Team Leader is to assign to members of the MET team. As outlined in the response to recommendation 1, the Justice Health Forensic

Mental Health Network has implemented an education plan with scheduled monthly MET simulation-based training. This includes the MET Leader Project Plan which comprises of a training needs analysis, education plan and performance criteria for assessing participating senior staff.

Recommendation 19 – Completed

The Justice Health Forensic Mental Health Network has developed an audit tool in the QARS to monitor staff compliance with the Clinical Procedure Long Bay Hospital- Clinical Emergency Response and Medical Emergency Team. The audit will assist in monitoring the quality of healthcare services and be used to create action plans to drive change through training, education and increasing awareness of clinical staff at network and facility level.

In support of NSW Health's commitment to reducing and, where possible, eliminating the use of seclusion and restraint, the Network has established the Forensic Hospital Seclusion and Restraint Reduction Committee (SARRC) to oversee seclusion and restraint practices. The SARRC and the senior management team at the Forensic Hospital partner with consumers to evaluate seclusion and restraint data for quality improvement.

The SARRC has made a commitment to the reduction of seclusion and restraint across the Network, with a continued focus on the implementation of the following 'Six Core Strategies':

1) leadership in organisational culture change
2) using data to inform practice
3) workforce development
4) inclusion of families and peers
5) specific reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation and customer services)
6) rigorous debriefing.

Recommendation

20. That pursuant to section 151A of the Health Practitioner Regulation National Law (NSW) No 86a, the transcript of the evidence of Registered Nurse Charles Xu be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Registered Nurse Xu on 29 December 2015 should be the subject of review.

Agency/Organisation

Chief Executive, Nursing and Midwifery Board of Australia

Response recorded as at February 2021

No response

Inquest into the death of Rebecca Maher (2019)

Recommendation

1) That the Attorney General consider amending the Law Enforcement (Powers and Responsibilities) legislation to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the Aboriginal Legal Services CNS as an Aboriginal person detained under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and
2) That the Commonwealth Minister for Aboriginal Affairs continue to work with the NSW Government on funding options and on potential improvements to the Aboriginal Legal Services CNS model to enable it to provide its services to Aboriginal people detained under Part 16 of LEPRA.

Agency/Organisation

Attorney General of NSW and Commonwealth Minister for Aboriginal Affairs

Response recorded as at February 2021

July 2019- The Attorney General has received the Coroner's recommendations and is considering the recommendation made to his administration.

[NOTE: While not reflected in the published response table both recommendations have been implemented. On 11 October 2019 clause 37 of the *Law Enforcement (Powers and Responsibilities) Regulation 2016* was amended to ensure that the CNS requirements are extended to Aboriginal persons detained under Part 16. On 9 June 2020 the Commonwealth Minister for Indigenous Australians confirmed that the Commonwealth would provide $3 million funding to the CNS to June 2013.]

Recommendation

1) That the NSWPF consider improvements to its education and training of police officers to provide clear and understandable information as to the nature of infectious diseases and associated risks.
2) That the NSWPF consider improvements to its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained.
3) That the NSWPF consider the implementation of a requirement that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course which would include education and training as to:
    a) The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a 'responsible person'; and
    b) Content of the NSWPF poster 'Safe Custody – Medical Risks' including that when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that a person can or will 'sleep it off'.

4) That the NSWPF consider modification to the custody management system to require the custody manager:

   a) When making entries for inspections to record, where the detainee is intoxicated, 1) what occurred when the custody manager attempted to rouse the detainee and 2) the custody manager's assessment of the detainee's level of consciousness; and

   b) to record the efforts they have made to identify and locate a 'responsible person' including consulting previous custody management records.

5) That the NSWPF continue to review the circumstances of the death of Rebecca Maher at Maitland Police Station as a case study in training of police officers who are to undertake the duties of a custody manager.

Agency/Organisation

Commissioner of Police NSW

Response recorded as at February 2021

Recommendation 1

Supported. All custody courses are currently being redesigned with a Custody Pathway Model being developed, and modules moving online and made available to all police officers at any time. A Work Health and Safety session on infection control and biological hazards is delivered to policing students at the Academy and forms party of the Safe Custody Course delivered to police. NSWPF was involved in a cross police jurisdictional study of police and Blood-Borne Viruses. Following the study, a resource booklet was developed by the Australian New Zealand Policing Advisory Agency (ANZPAA). Most of the contents of the ANZSPAA booklet is covered in the Safe Custody Course. The booklet is given to all policing student s and training participants as a handout and will be placed on the NSWPF intranet site.

Recommendations 2 and 3

Supported. All custody courses are being reviewed and where required, redesigned to build an incremental custody pathway. A blended methodology will enable flexibility in learning and increased availability for all NSW Police officers. Part of this body of work will be considering the qualifications required to perform the role of Custody Manager.

The proposed custody Pathway Model will have three levels of training:

1. Custody Fundamentals: Is being developed for online delivery which will be available to all police at any time;
2. Advanced Custody Course: This course will be a blend of on-line and a two-day face-to-face module.
3. A refresher/reaccreditation on custody for Custody Managers will be implemented to occur every 2 years.

Learning resources were released state-wide on 14 December 2018 and 9 April 2019 respectively via email to all NSWPF employees with links to the videos, ensuring their immediate accessibility to all police. The learning focused on the appropriateness and lawfulness of conducting strip searches in custody. The resources are also accessible to all police via the NSWPF Intranet.

A Mandatory Continuing Police Education (MCPE) module went "live" in August 2019. The module has been developed to address the Coroner's recommendations, and comprise components on LEPRA/police powers, general search and strip searching of persons detained/arrested in police custody, assessment process and inspections, next of kin (NOK), responsible person and support person, property, detention of intoxicated person, prisoner handover, and infection control.

The new Custody courses/modules will continue to emphasise and reinforce the requirements of an officer to identify a Responsible Person and NOK. The Custody Management Systems (CMS) is undergoing changes to better enhance the process. It will be mandatory that any screening relating to a NOK/Responsible Person will require the officer to add information on their efforts to locate and contact a NOK/Responsible Person.

A state-wide message was emailed to all police that reiterated their responsibilities when assessing all prisoners entering custody.

The 'Safe Custody: Medical Risks' poster will be revised and incorporate the Coroner's recommendation. The content of the poster forms part of the mandatory MCPE Custody Package for the 2019/2020 training year.

In addition, the NSWPF Person Search Manual was released in August 2019 which assists police in identifying the circumstances in which it is appropriate to search persons in custody.

Recommendation 4

Supported. Amendments to the CMS incorporating the terms of the State coroner's recommendation are currently under development.

Recommendation 5

Supported. A case study has been developed and included in the Advanced Custody Course and the Custody Fundamentals Module (online) and includes the management of Aboriginal and Torres Strait Islander prisoners, locating next of kin and powers in regard to detaining intoxicated persons.

A desktop screen saver has also been developed that reminds Custody Managers, Custody Officers and all other police involved in the custody and care of prisoners, to make timely inspections of prisoners in their custody,

Inquest into the death of AJ (2015)

Recommendation

I recommend that Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see the Justice Health Mental Health Team be rescheduled at the new Correctional Centre.

I recommend that the Drugs and Therapeutic Committee of Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider:
(a) reviewing the current procedures as set out in 6.6.1of the Medication Guidelines.(b) training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines.(c) reviewing communication between Justice Health and Corrective Services on issues relating to an inmate's non-attendance for antipsychotic medication.

Agency/Organisation

Minister for Health

Response recorded as at February 2021

1) That Justice Health review practices and procedures in relation to the transfer of inmates between correctional centres for the purpose of ensuring that any outstanding mental health reviews or existing appointments to see to the Justice Health Mental Health Team be rescheduled at the new Correctional Centre.
2) That the Drugs and Therapeutic Committee of the Justice Health and Forensic Mental Health Network be provided with a copy of these findings and consider:
    a) Reviewing the current procedures as set out in 6.6.1 of the Medication Guidelines and Training Justice Health staff in relation to the requirements of 6.6.1 and 7.7.3 of the Medication Guidelines

Inquest into the death of Terry Griffiths (2011)

Recommendation

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 liaise 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.

Agency/Organisation

Justice Health

Response recorded as at February 2021

On 6 December 2011 the Minister responded to the State Coroner and advised:

Recommendation 1 - Supported in principle

Justice Health (JH) provides health care to inmates in more than thirty (30) correctional centres as well as detainees in Juvenile Justice Detention Centres and to persons in a variety of community settings. Epidemiological research by JH and others has shown that persons in contact with the criminal justice system tend to have significantly higher physical and mental health needs than those of the general population. JH strives to provide the full range of clinical services to meet the complex health needs of its client group whilst acknowledging its resources are finite. Whilst JH would support increasing the resources directed to mental health services, such action cannot be done in isolation, rather it can only be achieved by directing resources away from other areas of equal need.

Recommendation 2 - Not supported

Justice Health is committed to providing the highest quality care to persons in custody. In accord with international best practice and the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, mentally ill persons should be treated in specialised facilities. JH and mental health clinicians consider that the present conditions operating in correctional centres with regard to staffing levels and access to patients render it clinically unsafe to involuntary treat mentally ill persons in the Mental Health Screening Units (MHSU).

Presently, patients from the correctional system who require involuntary treatment can be admitted to, and safely treated in the Mental Health Unit of Long Bay Hospital which is a declared mental health facility. In addition, as soon as local procedures are agreed between Justice Health and Corrective Services NSW (CSNSW), correctional patients will be able to be admitted to the Forensic Hospital for involuntary treatment. Both the Mental Health Unit in Long Bay Hospital and the Forensic Hospital are specialised units designed to enable the delivery of safe and effective care and treatment.

The legal capacity of the MHSU to detain patients is not considered relevant as Mr Griffiths was assessed by a JH doctor as not requiring involuntary mental health treatment. Therefore, if a person in the MHSU has been clinically assessed as requiring involuntary treatment, capacity already exists to have the person made a correctional patient and transferred to the Long Bay Hospital which is a declared mental health facility empowered to provide involuntary treatment.

Recommendation 3 - Supported

On 15 December 2010 JH published the *Procedure Manual for Forensic Community Treatment Orders (FCTO)* on its Intranet. The Procedure Manual sets out the JH system, procedures and forms for the making and implementation of FCTO in correctional centres. This action satisfies the recommendation.

Recommendation 4 - Supported

The decision to apply for a FCTO for any individual patient is a clinical one made by the patient's treating team. In making a decision to apply for a FCTO, the treating team must consider a number of factors, including the health needs of the patient, the resources available to implement to FCTO and, most importantly, whether making the FCTO would add to the management of and be beneficial to the individual patient concerned. Where all criteria are met, treating teams can and do apply to the Mental Health Review Tribunal for a FCTO.

Recommendation 5- Supported

JH has existing systems in place to ensure that relevant information is provided to the appropriate staff members of CSNSW to advise them of the salient health risks of inmates in order so that CSNSW staff can make informed decisions regarding placement. JH has had *Policy 1.231 Health Problem Notification Form (Adult)* in place for many years which sets out the procedure by which clinical staff can inform custodial staff of any health risks of an inmate that may impact on the wellbeing or accommodation of needs of the person. Relevant alerts entered into the JH Patient Administration System are automatically transferred to the CSNSW Offender Information Management System.

Whilst JH makes recommendations to CSNSW regarding the placement of inmates based on an individual's health needs, CSNSW is ultimately responsible for inmate placement

Inquest into the death of James Llewellyn Drury (2011)

Recommendation

That where the 'Knock Up' facility is used by an inmate, such use, and the corrective services officer response thereto, be recorded and such recordings thereof be retained for an appropriate period.

Agency/Organisation

Commissioner of Corrective Services

Response recorded as at February 2021

On 7 April 2011, Commissioner R Woodham PSM advised:

"The coronial findings and recommendation arising from the death in custody of inmate Drury are being considered by the Board of Management, 'Management of Deaths in Custody Committee' within Corrective Services NSW."

Further update (undated): Corrective Services NSW (CSNSW) is reviewing expert advice with regard to implementing the recommendation made by the Deputy State Coroner. As part of the costs-benefit analysis, CSNSW is considering the feasibility of installing audio recordable intercom devices within existing building/ system infrastructure as well as voice recordable devices in the construction of new correctional centres.

Inquest into the death of Paigh Bartholemew (2017)

Recommendation

1. That the induction process for any new inmate to the Emu Plains Correctional Centre and any information provided (in writing and orally) during that process should specifically note:
   a) The presence of the duress alarm within each house.
   b) If the alarm is pressed it will sound in the Administration Centre to alert Corrective Services staff who will attend the house.
   c) Pressing the alarm will not cause an alarm to sound nor a light to flash within or around the house.
2. That the Commissioner of Corrective Services give consideration to approaching the Commissioner of the New South Wales Police Force to request update briefings on current concealment methods and packaging for heroin, so as to assist in detecting contraband within New South Wales Correctional facilities and training Corrective Services staff.

Agency/Organisation

Commissioner of Corrective Services

Response recorded as at February 2021

The Commissioner has advised the Attorney General as follows:

Recommendation 1

a) The Emu Plains Correctional Centre (EPCC) local handbook 'Welcome to Emu Plains' (Aug 2017) and the EPCC reception interview form have been amended to include notification of the presence of duress alarms within each house and inmates are informed that the alarm, if pressed, will sound in the Administration Centre to alert CSNSW staff, who will respond. This information is relayed to inmates by the reception committee held by the Case Management Team.

b) The EPCC local handbook and the reception interview form states if the alarm is pressed it will sound in the Administration Centre to alert CSNSW staff to respond.

c) Pressing the alarm will not cause an alarm to sound nor a light to flash within or around the house. In the EPCC local handbook it states that 'when the alarm is pressed it will ONLY sound in the administration centre to alert CSNSW staff, who will attend the house. Pressing the alarm will not cause an alarm to sound or a light to flash within or around the house'.

In the EPCC handbook there is one page dedicated to the use of the emergency duress alarm. Also included in the reception interview form is a notation for the inmate to acknowledge that they have received instruction on the use of the duress/ knock up alarm system at EPCC.

Recommendation 2

CSNSW and NSWPF have enjoyed a long standing relationship where intelligence and information about criminal methodology is exchanged. The CSNSW Correctional Intelligence Group (CIG) and the Security Operations Group (SOG) are constantly monitoring the changing methods of concealment used to traffic contraband into correctional centres.

CSNSW and NSWPF often undertake joint visitor interdiction operations which are highly effective in intercepting contraband carried by visitors.

The EPCC will contact the nearest NSWPF Local Area Command to request regular updates on drug concealment techniques and packaging to assist in updating staff in the management of drug contraband at the Centre.

Concealment methods/ packaging are currently forwarded to all staff via intelligence reports from the CIG who work in conjunction with the NSWPF and Federal Police to receive their information.

SOG currently have an intelligence officer specifically for their unit to retrieve all forms of information from the COG and other sources. This position is a conduit between correctional centres and CIG to provide tactical intelligence for SOG.

NSW Office of the State Coroner
NSW Department of Communities and Justice