INQUEST INTO THE DEATH OF SCOTT ASHLEY SIMPSON

Brief facts

Scott Simpson was taken into custody at the Metropolitan Remand and Reception Centre ("MRRC"), bail refused, around 3.50pm on 30 March 2002. He was granted protection and, about 6.10 pm, he was placed in a two-out cell with Andrew Parfitt who was also in protective custody, having entered the MRRC the previous day following revocation of his parole. Within 15 minutes Simpson had brutally attacked Parfitt, inflicting fatal injuries. The following day Simpson was placed in segregation. Except for two short periods, he remained in solitary confinement at various prisons until he hanged himself in his cell on 7 June 2004.

On 31 March 2004 Simpson was found Not Guilty of the Murder of Parfitt. Bell, J. in the Supreme Court ruled that at the time he killed Parfitt two years earlier Simpson was suffering from a mental illness. Her Honour had before her expert evidence from three psychiatrists, Dr Lucas, Dr Westmore and Dr Greenberg, describing Simpson as suffering from paranoid schizophrenia. Each expressed the opinion that at the time of the attack Simpson was suffering a psychotic episode.

It is pertinent to emphasise that Simpson was in prison not because he had been convicted of an offence and given a custodial sentence. Initially, he had been remanded in custody for alleged offences involving violence. As the history set out below illustrates, those attacks occurred when Simpson was suffering paranoid delusions. The subsequent attack on Parfitt in prison occurred in similar circumstances. The evidence before me indicates that Simpson's mental illness was not something incidental to his incarceration. His delusional beliefs and his actions in accordance with them were the very reason he was in custody.

Although Simpson was reviewed by seven psychiatrists over the next two years, there was no opportunity for a therapeutic relationship with any of them. Hence, the only on-going treatment he received was antipsychotic medication, which he took intermittently. There was evidence before me to indicate that medication should only ever be part of an overall treatment regime.

A post mortem examination conducted by forensic pathologist, Dr McCreath, confirmed that Simpson had died by hanging. There was no evidence of any trauma or struggle that would suggest that anyone else was with him at the time of his death. She also indicated that the toxicological blood analysis revealed no antipsychotic drugs were present when he died.

Scope of Inquest

As Simpson died while in custody, it is mandatory under Section 13A(1)(a) of the Coroners Act 1980 to hold an inquest. There were many issues raised that were pertinent not only to Simpson personally but to the treatment of mentally ill inmates and forensic patients in prison generally. In order to appreciate both the clinical and the systems parameters of Simpson's incarceration I had before me evidence from the following:

- The seven psychiatrists who reviewed Simpson;
- Senior staff from the Department of Corrective Services ("DCS") involved in the decision-making about Simpson's placements;
- Senior staff from Justice Health involved in administering the hospital facilities at Long Bay;
- Staff from both Justice Health and DCS who had relevant dealings with Simpson;
- The President of the Mental Health Review Tribunal

as well as some fifth documentary exhibits including medical records, DCS records and policy and procedure documents.

The focus of the inquest was, perforce, on the manner and cause of Simpson's death rather than a general inquiry into the treatment of mental illness in a custodial setting. Nevertheless, I am satisfied that where I have made comment or recommendations about systems generally, the material before was extensive enough to provide a sound basis for doing so.

History

Simpson had a lengthy criminal history. It is not necessary for me to review that in detail. Suffice to note that from his previous terms of custody, DCS had documented a history characterised by self-harm attempts, violence and mental illness.

In order to place the events of March 2002 in perspective it is instructive to look at what was happening in Simpson's life during the previous six months. On the 12 October 2001 police were called to premises in Granville where Simpson was seen to climb over garage roofs. He told police that he was being watched by ASIO and the NCA. He was subsequently admitted for treatment of a psychotic episode to Cumberland Psychiatric Hospital on the 19 October 2001. Following his discharge on 31 October 2001, he went to Coffs Harbour to see his family. His behaviour became violent and bizarre and he was charged with offences arising out of assaults on family members. He was seen by a psychiatrist whilst in custody at Coffs Harbour and was prescribed anti-psychotic medication. He was moved to Grafton then to the MRRC on 11 November 2001. He was initially placed in a two out cell. On 12 November he was also placed, at his request, in protective custody (limited association). The two out placement was reviewed on 13 November when he made homicidal threats to his cell-mate. Also on 13 November 2001 a Mandatory Notification Form for inmates at risk of Suicide or Self Harm was completed and a Risk Assessment Intervention Team (RIT) convened. On 16 November a notation on his file indicates that he was on the waiting list for D Ward – the acute psychiatric ward within Long Bay Hospital. A further note on that day recorded, “Inmate is presently at risk to himself and others”. An entry on 18 November records a meeting between a psychiatrist and Simpson the previous day and confirmed that Simpson was going to D Ward. However, placement in a two out cell was now permitted. On 20 November the RIT was terminated. Also on that day Simpson was seen by Dr Ahmed who did not consider that he was mentally ill. Presumably, as a consequence of this diagnosis, his name was removed from the D Ward waiting list.

Simpson was discharged from the MRRC on 14 January 2002. However, I note that the Discharge Summary by DCS was not completed until 31 March 2002. On 27 March 2002 Simpson attended Parramatta Police station requesting to be taken into custody because he had failed to comply with the reporting requirements of his bail. Concerned with aspects of his behaviour, police officers conveyed him to Cumberland

Hospital but he was not assessed as being mentally ill within the meaning of the *Mental Health Act 1990*. Simpson was released on bail. On 29 March he initiated an unprovoked attack to a person and his vehicle while having a psychotic episode. The Custody Manager at Windsor Police Station, where Simpson was taken after his arrest, considered that Simpson could "snap" at any moment. The following day, 30 March 2002, he was taken to the MRRC.

Simpson was psychotic on 29 March. He was also psychotic, according to three psychiatrists, on 30 March. Why was his mental state not identified at his Reception Assessment on 30 March by Justice Health staff?

Reception Assessment

When he was interviewed by Nurse Kumar from Justice Health, Simpson appeared "co-operative, alert and orientated". She stated that her assessment relied totally on the interview - she had no access to previous Justice Health records or Department of Corrective Service records at the time of interviewing Simpson. The Medical Alert Form that she completed has the following boxes ticked: general impulsive behaviour, violence to others, serious mental illness, suicide attempt while seriously mentally ill, illicit drug use, unintentional illicit drug overdose, self-harm behaviour – hanging. Yet the information as provided by Simpson himself does not provide a context and certainly does not convey his recent pattern of behaviour as set out above, most importantly the recent assault while under the influence of delusional beliefs. Hence, the medical alert form carries the notation "SMI" and recommends a two out cell placement, because of his previous suicide attempts. In the Justice Health file there is a note that Simpson should be referred to a psychiatric nurse.
I note that, on a previous occasion when Simpson was in custody, Nurse Kumar had, in the course of her duties, given him anti-psychotic medication. However, she was unaware of the details of his mental illness.

As mentioned previously, the discharge summary in relation to Simpson's discharge on 14 January 2002 was completed on 31 March 2002 – a day after the ferocious attack on Parfitt. It provides information that should have been available to Justice Health in determining Simpson's placement,

" This inmate is a danger to staff and other inmates. He has made numerous threats against staff and has been involved in inciting other inmates to violence. He is unpredictable and violent, is alleged to be involved in standover tactics and drug trafficking. Extreme caution should be used at all times. Do not see this inmate alone. He has a history of mental illness and has made homicidal threats against his cell mates. He has been under RAIT management on numerous occasions, has an extensive history of self-harm and self-harm thoughts. He is an escapee and poses a high risk of escape."

After he had been assessed by Justice Health but prior to being placed in his cell, Simpson punched another inmate in the reception area without provocation. This incident was not reported to Nurse Kumar at the time so that the initial decision about Simpson's placement could be reviewed if necessary. According to the Custodial staff at Reception "punch ups" are not unusual. Nevertehless, it was an important indicator of Simpson's mental state and ought to have been reported to Justice Health.

Nurse Kumar gave evidence that if she had known about the assault she definitely would not have recommended a two out cell placement. She stated that she would probably have put Simpson in an assessment cell because of his previous suicide attempts and then have the mental health nurse review him in the morning. She stated, "I never ever put an agitated person or a person that assaults others with someone else."

Issues

1. *Access to records*

   I am satisfied that the new Reception Triage Process which has been operational for the past two years has markedly improved the information flow from the Department of Corrective Services to Justice Health staff performing reception assessments. The means is not only via files but also by computer link. However, the evidence indicates that the Justice Health files may not always be available for

the reception interview, particularly of a weekend. It seems to me that Justice Health ought to generate a Discharge Summary from a health/mental health perspective and that this information should be recorded on computer so it can be accessed during the reception process as well as information from DCS.

2. *Discharge Summary – DCS*

Under the system of information exchange in 2002 the DCS Discharge Summary would probably not have been available to Justice Health staff prior to the reception assessment. In Simpson's case it most definitely would not have been available because it was not completed until the day after Simpson was assessed and the attack on Parfitt occurred. It seems to me that the Summary needs to be completed within a reasonable time frame, say 14 days, after the inmate is discharged.

I note that the documented procedures for the Discharge Summary Unit emphasise the need for Justice Health to have the summary for screening "at risk of suicide" inmates prior to the initial assessment. This reference needs to be expanded to include not only instances of self harm but harm to others as well.

3. *Mental health assessment prior to placement*

I note the formation of the Mental Health Screening Unit located at the MRRC and opened on 6 February 2006. This should enhance the ability of Justice Health to identify those remand prisoners with a mental illness and to facilitate an appropriate clinical response.

4. *Notification of harm or attempted harm to self or others after review & prior to placement.*

Ms Kumar was not notified of the assault by Simpson on another inmate in the period between the conclusion of her session with him and his placement in the cells. Any such instances of behaviour must be reported back so that they can be taken into account and the initial assessment revised, if appropriate.

Appropriateness of Placement

It is obvious from my comments above that I consider Simpson ought not to have been placed two-out. Least of all should he have been placed with Parfitt. Parfitt had previous suicide attempts and was placed in a safe cell with the requirement of continuous clinical observation. Parfitt had requested protection on the basis that he feared for his life and welfare. (Parfitt was a convicted paedophile whose parole had been revoked). On the RIT Management Plan drafted for him on 30 March, there is a notation that the risk from others is high and that he was afraid of being assaulted.

There is no indication on the Protective Custody Direction form whether Parfitt was to be detained in isolation or in association with such other inmates as the Commissioner (or governor on his behalf) may determine. Certainly, no other inmates were nominated as being safe for him to associate with.

Evidence was given that when neither box was ticked the inmate was to become a Special Management Area Placement ("SMAP") prisoner pursuant to Clause 32 (3)(b) of the Crimes (Administration of Sentences) Regulation 2001. I understand that the procedure attached to SMAP placements has changed since March 2002 so I do not intend to review the provisions of the Regulation in detail. Suffice to note that there is a particular form that needs to be completed for SMAP placements and it is not the Protective Direction form. From a substantive point of view, the Commissioner, or Governor in his stead, was required by Section 12 Crimes (Administration of Sentences) Act 1999 to nominate the type of protective custody that had been granted to Parfitt. He did not do so. Since no one had been nominated as suitable to associate with Parfitt, no one should have been permitted to share his cell. With his history of violence and recent assault, Simpson should never have been considered as a suitable cell mate for Parfitt.

Treatment for Mental Condition

In the aftermath of the attack on Parfitt, Simpson was placed in segregation. Dr Murphy examined him and concluded that he was suffering from paranoid psychosis. He completed a Schedule Three under the Mental Health Act 1990, although it has not been co-signed by another medical practitioner as required by Act. Nor is it clear whether Dr Murphy intended to invoke the provisions of Section 98 or 97 of the Act.

From his other comments, however, I infer that Dr Murphy had formed the opinion that Simpson was a mentally ill person and required treatment in hospital. Without a second signature, the Schedule is incomplete and there is no evidence that it was ever placed before the Chief Health Officer as required under the Act. However, Simpson's name was to be placed on the D Ward waiting list. The other components of the plan set out by Dr Murphy was that Simpson was to remain on his anti-psychotic medication, be seen daily by mental health staff and be reviewed frequently by a psychiatrist.

I intend to comment later on the system of the waiting list for D Ward and how it was administered. At this point I will note simply that Simpson had not been transferred to D Ward before he was transferred to the Multi Purpose Unit ("MPU") at Goulburn Correctional Centre on 26 April 2002. I do not know the condition of others who were waiting for admission to D ward at that time. However, it seems that Simpson should have been very high on the priority list – he was demonstrably acutely mentally ill to the extent that he had killed another person. However, instead of receiving treatment in hospital he was sent to a segregation cell in the MPU with minimal opportunities for adequate psychiatric care. That initial move to Goulburn typified how Simpson was dealt with during the rest of his time in custody, namely:

a) mental health professionals in regular contact with Simpson advocated strongly for his hospitalisation;
b) those making the decisions about priorities for admission to D Ward did not accord him sufficient priority for the transfer to hospital to be effected; while
c) DCS focused on security aspects and kept Simpson segregated;

The result was that while Simpson's condition fluctuated depending on whether he was compliant with his medication, the time spent in segregation lead inevitably to a deterioration of his mental state until the crisis point was reached on 7 June 2004.

On 7 January 2003 Professor Greenberg in a report to the Serious Offenders Review Committee noted that Simpson was suffering a mental illness and required treatment in a psychiatric hospital. In a later undated report Greenberg reiterated his earlier comment and added that Simpson required psycho-education about his illness and

needed to see a psychiatrist on a weekly or fortnightly basis. At that time a psychiatrist visited Goulburn for six hours per fortnight. There was no opportunity, therefore, for Simpson to receive the medical attention that he needed. That fact was drawn to the attention of the Director Mental Health, Ms Doherty, by Nurse Ricardo of the Goulburn Clinic in a letter dated 3 April 2003. By that time Simpson had moved from 33 to 32 on the D Ward waiting list.

It is significant to note Simpson had no insight into his illness. This accounts for the fact that he was noncompliant with his medication for long periods. It also accounts for his refusal to see psychiatrists and other mental health staff on occasions. For example, Dr McGrath noted on 3 April 2003 that Simpson had refused to see him. Indeed the Secretary of the Serious Offenders Review Council wrote to the Chief Executive Officer of Justice Health on 15 May 2003 outlining that since 30 March 2003 Simpson had refused to see medical staff or take his medication. The letter further enquired whether Simpson would be suitable for placement in D Ward.

On 20 June 2003 Ms Doherty accompanied Dr Samuels, Senior Consultant Forensic Psychiatrist and A/Clinical Director, to interview Simpson in Goulburn. Dr Samuels assessed Simpson, found he was compliant with his medication at that time and presented as mentally well. When questioned about the possible reason Simpson presented as mentally well to Dr Samuels, Dr McGrath commented that Simpson could appear rational for short periods if he wanted to but could not maintain that presentation for any length of time. He considered that Simpson's psychosis was fairly constant. The consequences for Simpson following the assessment by Dr Samuels was that his name was removed from the D Ward waiting list.

Dr Samuels considered that his assessment Simpson's mental state was vindicated because Mr Simpson remained safe for almost a year. However, Dr Samuels did concede that Mr Simpson's mental state deteriorated during that time.

It was submitted to me that Simpson was not disadvantaged because of his omission from the D Ward list because he could be added to the list at any time. The system did not operate so that those at the top were necessarily given the next available bed. The criteria was clinical need. However, the evidence indicates that being on the list

should have ensured that Simpson's condition was reviewed on a regular basis by Dr White, psychiatry registrar at Long Bay, who decided on the priority of admissions to hospital.

The other consequence of Dr Samuel's decision was that Simpson remained at Goulburn where, apart from medication, he was offered no therapeutic treatment. Dr McGrath indicated that his attendance at Goulburn six hours per fortnight simply did not enable him to engage in any meaningful therapeutic relationship with Simpson. In my opinion, the decision whether to admit Simpson on 20 June 2003 should have been based on more than his presentation on that one occasion. There was no doubt that he had a mental illness although his condition fluctuated through phases of stability and instability. The prognosis for the illness needed to be taken into account, particularly in view of the fact that Simpson was kept in solitary confinement at the HRMU. Justice Health had a responsibility not only to ensure that Simpson did not self-harm in the immediate future but also to ensure he received the treatment needed to prevent his mental deterioration over a longer period. It is in the latter area that Justice Health failed.

Transfer to Long Bay Hospital Area 2 ("LB2")

This facility was previously referred to as a transit centre and, according to the evidence, it is still utilised for that purpose. It is one of two metropolitan centres that have segregation facilities and inmates on Segregation Orders who on have to attend court in Sydney are housed there for the duration of their court appearances. It was on this basis that Simpson was brought to LB2 on 22 March 2004.

Following the finding of Not Guilty on the grounds of Mental Illness on 31 March 2004 Simpson remained in Area 2. According to Dr Lewin, consultant psychiatrist, Simpson's name was returned to the D ward waiting list on 1 April 2004 because of his legal status as a forensic patient, not for any clinical reason. Dr Lewin first saw Simpson on 8 April and conducted a detailed examination on 29 April, at which session Simpson was manacled. He diagnosed Simpson as suffering from Paranoid Schizophrenia, in partial remission, and recommended hospitalisation. Dr Lewin was gravely concerned about Simpson's mental state and agitated to have him transferred

to D Ward as quickly as possible. Dr Lewin saw him again on 6 May, at which time he decided that a cross-disciplinary team needed to be set up to manage Simpson's behaviour. On 3 June when Dr Lewin was next expected to see him, Simpson was "locked down". He was refusing to take his medication.

Dr Lewin stated in evidence that he was so concerned about being unable to get Simpson into hospital that he threatened to call the Minister. He described his exasperation in these terms:
"I have never had a higher index of concern about a patient. I felt powerless because it was absolutely apparent that he needed to be cared for in hospital and this was not happening."
Later in his evidence he stated:
"My concern was that someone was going to get killed……my concern was that a member of staff might have been harmed and I had almost the same index of concern with regard to Mr Simpson himself."

From 10 May 2004 Simpson was number one on the list for admission to D Ward. However, on 1 June when the next bed became available another patient was given priority. Justice Health staff have consistently denied that Simpson's security classification in any way influenced decisions in respect of his placement. However, it is understandably difficult for the Simpson family to accept that after being told that Simpson could not be admitted throughout all of April because he was not at the top of the list, he then waited for a month as number one without securing admission and was subsequently passed over when the next bed became available.

According to Ms Doherty a bed became available on the afternoon of 7 June but owing to the late notification, DCS transport for the transfer could not be organised until the following day. I note that the actual discharge records for D Ward show that a patient was discharged on 4 June. Ms Doherty explained that there had been an overflow of D Ward patients into B Ward and that it seemed as if a patient had been transferred back to D Ward from B Ward. However, I note that there is no entry on DCS records that Simpson was to be transferred on 8 June. In the circumstances I am dubious that any arrangements had been made. After reviewing all the evidence I have

reached the conclusion that Justice Health administrators were reluctant to admit Simpson to D Ward, whether unconvinced of the clinical urgency or because of security considerations or a combination of both, I am unable to determine.

Certainly, one important aspect in the lack of urgency in respect of finding a bed for Simpson was the inadequacy of reviews of his condition undertaken by Dr White. Although Simpson's medication chart clearly indicates that he was noncompliant with his medication during his time at LB2, Dr White stated that he was unaware of this fact. Significantly, he gave evidence that had he been aware, it would have affected the decisions he made about prioritising Simpson's admission. Whether Simpson was taking his medication was crucial to his mental wellbeing. That this factor was not ascertained before deciding on his need for hospitalisation was a most serious omission. I note in addition that information about Simpson's non-compliance was specifically relayed to Ms Doherty by Simpson's mother around 27 May. Yet the information did not reach Dr White. **Dr White's response in court obviously showed that more could have been done to secure a hospital bed for Simpson. It wasn't. It ought to have been.**

On 7 June 2004 Simpson appeared at Penrith Local Court for the matters in respect of which he had been bail refused. The charges were withdrawn. He arrived back at LB2 at 1.16 pm. In just under seven hours later he was found hanging in his cell.

D Ward Waiting List

In the period under review, Long Bay Hospital comprised four wards that comprised the following facilities for male patients:
A Ward – 30 beds for long-term mental health patients;
B Ward - 17 general medical beds (including female patients as well);
C Ward – 30 beds for sub-acute mental health patients;
D Ward – 29 beds for acute mental health patients.

Movement of Forensic Patients

Demand for beds in D Ward far exceeds the supply. One reason is simply the number of mentally ill prison inmates who require hospitalisation. The other is that forensic patients who are found not guilty on the grounds of mental illness move very slowly through Wards C and A. According to Dr Lewin, mentally ill inmates outside hospital are often sicker than those in hospital. Evidence from Dr Chappell, President of the Mental Health Review Tribunal indicated that the NSW forensic system was structured so that the final decision on the release of forensic patients into the community rested with the Executive. Hence, there were political considerations that were involved in the decision-making process as well as clinical factors. He contrasted this with other States in which the decision rested in the hands of either a Tribunal or a division of the Supreme Court. The structure of the mental health review system was, however, not fundamental to this inquest and hence, I received little evidence on this aspect. Nevertheless, I am sufficiently concerned from the limited evidence before me to recommend a review of the present structure to ensure that the limited hospital beds available are accessed by those inmates who most need them.

Number of Beds

The number of beds available to forensic patients was clearly inadequate. As previously noted the opening of the Mental Health Screening Unit that opened on 6 February with 40 beds is an important initiative to ensure those entering prison with mental health problems are identified at an early stage and appropriately placed. Additionally, I heard evidence of the expansion of mental health services that is scheduled to occur over the next five years:-

- An 85 bed hospital complex jointly managed by DCS and Justice Health at Long Bay with 40 beds dedicated for mental health patients;
- A 135 bed maximum security hospital for forensic psychiatric patients at Long Bay administered by the Department of Health and managed by Justice Health;
- A medium security unit at Bloomfield which will also take forensic patients.

Priority Assessment

In the relevant period, determining which inmates were given priority for admission to the scant beds available in D Ward was the task of a psychiatry registrar at Long Bay, Dr White. If he could not assess prospective patients personally because of their location, Dr White would discuss their condition with mental health staff at their respective institutions by teleconference. I heard evidence that this task is apparently now carried out by a Committee. While I am sure there are many advantages of a committee structure, nevertheless the effectiveness of the decision-making process depends on the information available to it. I have previously drawn attention to the fact that Dr White was unaware of Simpson's non-compliance with his medication. Unless there is some way of guaranteeing that such vital information is available to the committee, then the structure is no guarantee of the efficacy of its decisions.

The other aspect that is of concern is that the process for consultant psychiatrists to draw their patients' needs to the hospital administrators was not clearly understood. For example, two of the psychiatrists who gave evidence considered it was not appropriate to complete a Schedule 3 until a bed in D Ward became available. However, Ms Doherty stated that this was not the case and a Schedule could be completed at any time. I note that the completion of a Schedule does have legal consequences in that, pursuant the Sections 97 and 98 of the Mental Health Act 1990**,** the Mental Health Review Tribunal has to be notified when a Schedule is received by the Chief Health Officer.

It was submitted to me that if Dr Lewin was so concerned about the lack of progress in securing a hospital bed for Simpson he could have gone over Dr White's head and approached Ms Doherty or the Clinical Superintendent directly. Yet this was not part of the system as understood by Dr Lewin or, for that matter, the other consultant psychiatrists who gave evidence. If there is to be an avenue for appeal against the decision of the committee now performing Dr White's previous role, it must be clearly articulated so that all those involved in the system understand the process. As far as I am concerned there is nothing to criticise in Dr Lewin's approach.

Indications of Suicide

Simpson had a documented history of suicide attempts, one occurring previously in the very cell in which he died. It was suggested in evidence that if Dr Lewin was so concerned about Simpson he could have convened a Risk Intervention Team. However, I note that Dr Lewin did not see Simpson after 6 May. Justice Health staff who saw him most regularly expected his imminent transfer to D Ward. They perceived his condition as chronic rather than acute. Those who gave evidence did not notice any significant change in his condition in the days prior to 7 June. In hindsight it is clear that Simpson ought to have been placed in a safe cell. On the other hand I have no information about what transpired on 7 June except that Simpson attended court and the charges were withdrawn. I cannot discount that there was something about the change of status or something else that occurred on 7 June that triggered Simpson's actions that night.

Segregation

On 10 April 2003 Simpson was placed on the High Risk Management Unit ("HRMU") Program. He remained on that program until he died. Initially he was located at the High Risk Management Unit at Goulburn. However, the program continued when he moved to another location. Indeed, no movement could be undertaken without the authorisation of the HMRU. The evidence indicates that being on segregation would not affect a person's admission to D Ward ie there are facilities for segregation available in the hospital.

However, the HRMU is solely the domain of DCS. All decisions about an HRMU inmate, including segregation, are made without any input from Justice Health. Pursuant to Sections 10(1) and 10(2) Crimes (Administration of Sentences) Act 1999, the governor of a correctional centre may direct that an inmate be held in segregated custody if of the opinion that their association with other inmates constitutes, or is likely to constitute, a threat to the security of a correctional centre, or good order and discipline within the centre. Simpson was initially placed on segregation on 10 April 2002. During the periods 17 June – 21 September and 11 October – 6 November Simpson was allowed to associate with one other inmate, although in the latter period the association was permitted only through a secure barrier.

From the time of his arrival at Long Bay Area 2 on 22 March 2004 Simpson was placed in segregation. The last Segregation Order was due for review on 21 June 2004. This meant that Simpson spent some 10 weeks alone in a cell for up to 22 hours per day. He was allowed access to a "day yard" for around 2 hours per day. This caged area has a shower but no facilities for exercise.

All of the psychiatrists who gave evidence stated that prolonged periods in solitary confinement would most likely exacerbate an inmate's mental illness, particularly if he were suffering from paranoia. As Dr Lewin commented,
"Solitary confinement is not a medical treatment. There is no circumstance in which that is appropriate in the care of a mentally ill person……I regard it as fundamentally inappropriate for someone as disturbed as this man (Simpson) to be in solitary confinement outside hospital."

Yet Justice Health had no input into Simpson's initial placement in segregation or any input into the review of the subsequent Segregation Orders. Moreover, Justice Health did not, in its own assessment of Simpson's condition, consider the prospective impact of extended periods in solitary confinement.

Mental Health Tribunal

One of the functions of the Mental Health Tribunal is to review the placement of forensic patients. Forensic patients include those inmates found not guilty on the grounds of mental illness and those who are "scheduled" under sections 97 or 98 of the Crimes (Administration of Sentences) Act 1999. Simpson became a forensic patient on 31 March yet the Tribunal was notified officially only shortly before his death, over two months later. If the Tribunal is to play an effective role, then it needs to be notified in a timely manner. I would have considered it appropriate for the court order to be sent by facsimile to the Tribunal within days rather than weeks. In any event, there ought to be a protocol between the Tribunal and the relevant courts setting out the maximum time-frame within which notification is to occur.

Procedures for Inmates found Hanging

DCS policy about what a Custodial Officer should do if he finds an inmate hanging in his cell is clearly set out, namely:

"Should the person be discovered hanging, the officer shall immediately cut the body down protecting the head and neck as much as possible. (If another officer is present, one officer supports the body whilst the other officer cuts the suspending item.) The need to preserve a 'crime scene' does not take precedence over the immediate requirement to cut down a hanging body. The procedure is as follows;

i) Lower the body to the ground;

ii) Remove or cut the noose while leaving the knot intact (observe the location of the knot on the neck);

iii) Check for signs of life; and

iv) Commence resuscitation and other appropriate first aid procedures and institute active resuscitation techniques until a medically qualified person takes over."

The policy stipulates that the steps of this procedure should be strictly adhered to. Yet the two officers who discovered Simpson hanging from the bars in his cell did not immediately attend him. They chose not to enter until a senior officer arrived. The reason they gave at the inquest was that they thought Simpson might be feigning and they were too concerned for their safety to approach him. On the other hand, Justice Health staff who viewed Simpson from the doorway to his cell considered that he was clearly deceased, yet they did not examine him. Another part of DCS policy advises staff that the absence of vital signs does not necessarily mean that a person has died. Therefore, the discovering officer must immediately commence resuscitation and first aid. Given the observations of Justice Health staff, this was a genuine hanging and the Custodial Officers should have rendered immediate assistance without waiting for a senior officer to appear. In this instance the policy is adequate. The response of the Custodial Officers was not.

Hanging Points in Cells

I note with approval the steps taken so far by the Department of Corrective Services to eliminate obvious hanging points in cells. I acknowledge it is a complex and costly task. However, I am concerned that the Manager of the Working Party for the Reduction of Hanging Points is engaged in that role only on a part-time basis. I intend

to recommend that the role be full-time so that the work can be concluded as expeditiously as possible.

Submission by Human Rights Commission

I gave leave for the Human Rights Commission to appear before the inquest. I have noted in particular submissions on behalf of the Commission that the long period that Simpson spent in segregation and his lack of care and treatment in an appropriate setting are contrary to some basic human rights' principles. I have taken these matters into account in formulating my recommendations.

FINDING

Scott Ashley Simpson died on 7 June 2004 when he deliberately hanged himself in his cell at the Long Bay Correctional Centre, Malabar.

RECOMMENDATIONS

To the Minister for Health

1. In relation to inmates of Correctional Centres who have been diagnosed with a mental illness and require treatment in hospital:

A. There should be a standardised procedure for admission to hospital.

- **That procedure should be based on the provision of Sections 97 and 98 of the Mental Health Act 1990 and the completion of a Schedule Three form. The procedure should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health Staff;**
- **The members of the Committee making the decisions about hospital admission (which has superseded Dr White's role) should hear personally from at least one of the medical practitioners who have examined the prospective patient and completed the Schedule.**

B. There should be standard criteria for admission to hospital to be taken into account by the Committee. The criteria should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health staff.

(a) The criteria should be based on the Principles for the Protection of Persons with Mental Illness, namely that persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings, and who are determined to have a mental illness, have the right to the best available mental health care;

(b) Specifically, in addition to the inmate's present clinical condition, the committee should have regard to:

- **Any likely deterioration in the person's condition;**
- **Whether the person has been placed in segregation and, if so, for how long;**
- **Any non-compliance with medication;**
- **The treatment options available outside a hospital environment, including the frequency of access to a psychiatrist.**

C. Those persons in respect of whom a Schedule Three has been completed but who cannot be immediately placed in hospital should be placed under the care of a nominated appropriately qualified medical practitioner, who will take responsibility for their treatment and who will provide up-dated reports for subsequent meetings of the Committee.

2. In order to ensure that all relevant information is placed before Justice Health staff at the time of the Reception Assessment of inmates ie. prior to the arrival of Justice Health files, a Discharge Summary should be completed by Justice Health staff on all inmates diagnosed with a mental illness within 14 days of their discharge. This Summary should then be made available in electronic form for access by Justice Health Reception staff in the course of all subsequent assessments on admission.

3. Given that decisions about placement within Correctional Centres and the release of forensic patients are made in other States by either an independent Tribunal such as the Mental Health Review Tribunal or by superior courts, a review should be conducted as to whether the present system of Executive responsibility is best suited to ensure the placement and movement of inmates on clinical grounds. The review should specifically assess whether, under the present system, the decision-making process about the movement of forensic patients ensures the best use is made of the limited available hospital beds.

<u>To the Minister of Health and the Minister of Corrective Services</u>

4. In relation to inmates with a mental illness, an integrated approach between Justice Health and the Department of Corrective Services should be adopted in decisions about placing those inmates in segregation and reviewing the relevant Segregation Orders to ensure that the consequences for the inmates' mental wellbeing are taken into account. As part of that approach:

- **An appropriately qualified medical practitioner nominated by Justice Health should examine the inmate within 48 hours after the initial placement in segregation and a written report should be forwarded from Justice Health to the Department of Corrective Services detailing any clinical concerns and recommendations to address those concerns;**
- **A similar assessment should then be conducted on a weekly basis and a written report forwarded to the Department of Corrective Services detailing any clinical concerns and concomitant recommendations.**

<u>To the Minister for Corrective Services</u>

5. The Department of Corrective Services should adopt the policy that inmates diagnosed with a mental illness should be placed in segregation only in exceptional circumstances and for a limited period.

6. The Department of Corrective Services should ensure that Discharge Summaries on all inmates are completed and can be accessed by Reception staff within a reasonable time, at least within 14 days, after an inmate's discharge.

7. The Department of Corrective Services should ensure that sufficient resources are allocated to the Working Party for the Reduction of Hanging Points, including the appointment of a full-time manager, to enable the current work of the group to be carried out at the earliest opportunity. Additionally, the scope of works should be expanded to include, on a priority basis, all cells in maximum and medium security institutions.

8. The Department of Corrective Services should implement a policy to ensure that any violent or other aberrant behaviour by an inmate at the time of reception into a Correctional Centre is immediately brought to the attention of the Justice Health Staff member conducting the reception assessment of the inmate. This should occur irrespective of whether the assessment has been completed.

9. The Department of Corrective Services should note that the policy in relation to immediately cutting down an inmate found hanging and commencing resuscitative efforts was not followed in this case. The Department should consider the best way of reinforcing that the policy should be complied with in all circumstances.

<u>To the Attorney –General</u>

10. A protocol should be developed between the referring courts and the Mental Health Review Tribunal to ensure that notifications of the court's decision that a person has been found not guilty on the grounds of mental illness occurs at the earliest possible time and, at the outside, no later than seven days.

Magistrate D. Pinch
Deputy State Coroner
17 July 2006