The Hon Anoulack Chanthivong MP
Minister for Better Regulation and Fair Trading, Minister for Industry and Trade,
Minister for Innovation, Science and Technology, Minister for Building,
Minister for Corrections

NSW GOVERNMENT

The Honourable Michael Daley Dip Law MP
Attorney General of New South Wales
GPO Box 5341
SYDNEY NSW 2001

21 May 2024

Dear Attorney General, Michael

I write in relation to Corrective Services NSW response to the *State Coroner's Annual Deaths in Custody/Police Operations Report 2023*. I understand the Report will be tabled in Parliament today. It appears there has been a miscommunication between Corrective Services NSW and my ministerial office resulting in my response and the progress report, dated 14 December 2023, not being received by your office or the NSW State Coroner.

I have attached the omitted material for your consideration and discussion with the State Coroner's Office. I would be grateful if you could explore what options may be available to include the updated information from CSNSW for inclusion or attachment to the Annual Report.

Sincerely,

22-5-24

Anoulack Chanthivong MP
Minister for Better Regulation and Fair Trading, Minister for Industry and Trade,
Minister for Innovation, Science and Technology, Minister for Building,
Minister for Corrections

52 Martin Place Sydney NSW 2000
GPO Box 5341 Sydney NSW 2001

02 7225 6170
nsw.gov.au/ministerchanthivong

Communities and Justice

Correspondence to Minister Chanthivong

Corrective Services NSW

The Hon Anoulack Chanthivong MP
Minister for Better Regulation and Fair Trading, Minister for Industry and Trade,
Minister for Innovation, Science and Technology, Minister for Building,
Minister for Corrections

Ref: D23/1368740

The Honourable Michael Daley DipLaw MP
Attorney General of New South Wales
GPO Box 5341
SYDNEY NSW 2001

Dear Attorney General, Michael

I provide the attached Progress Report on the implementation of coronial recommendations which outlines how the recommendations made by the Coroner have been addressed by Corrective Services NSW (CSNSW) to date (**Attachment 1**).

Coronial recommendations handed down in the following matters have been included in the Progress Report:

1. A [redacted]
2. GOOLAGONG, Ivan Leo (MIN 459238)
3. WILD, Milo (MIN 581484)
4. MACKANDER, Bailey (MIN 609005)
5. BUGMY, Kevin (MIN 140017)
6. ELLIS, Gavin (MIN 521980)
7. SAMUEL, Trevor Akimiller (MIN 352663)
8. KNIGHT, Kerry (MIN 254304)
9. ZA [redacted]
10. TOGATUKI, Junior [redacted]
11. DUNGAY, David (MIN 429471)
12. CHIU, Ye [redacted]
13. REYNOLDS, Nathan (MIN 392450)
14. ROBERTS, Roy (MIN 373080)
15. LT [redacted]
16. KT [redacted]
17. CJ [redacted]
18. RRC [redacted]
19. GS [redacted]
20. BUTTON, Reuben Clarke (MIN 393401) – Non-publication order exists
21. MILES, Simon (MIN 290248) – Non-publication order exists
22. GRIEVE, Matthew (MIN 623714)
23. SH [redacted]
24. GRETTON, Peter John (MIN 607040)

25. RP & DJ [redacted]
26. LP [redacted]
27. KOKAUA, Jack (MIN 385924) – Death in community – Non-publication order exists
28. THOMPSON, Gabriella – Death in community – Non-publication order exists
29. WALTON, Tafari – Death in community – Non-publication order exists

The Coroner has made the following orders:

- Of the death in custody of **LT and KT**, it is noted that their Honour pursuant to section 75 of the *Coroners Act 2009* [the **Act**], there is to be no publication of any matter that identifies the deceased persons and the deceased person's relatives. Pursuant to section 74 of the Act, non-publication orders have been made in relation to other evidence. A copy of the orders can be found on the Registry file.

- Of the death in custody of **CJ** it is noted that their Honour pursuant to section 75 of the Act that there be no publication of any material that identifies the deceased person or his family.

- Of the death in custody of **RRC** it is noted that their Honour pursuant to section 75 of the Act that there be no publication of any material that identifies the deceased person or his family.

- Of the death in custody of **GS** it is noted that their Honour made non-publication orders prohibiting publication of and access to certain evidence pursuant to the Act. A copy of these orders can be found on the Registry file.

- Of the death in custody of **Reuben Clarke Button** it is noted that their Honour made non-publication orders prohibiting the publication of various persons personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.

- Of the death in custody of **Simon Miles** it is noted that their Honour made non-publication orders prohibiting publication of certain evidence pursuant to section 74 of the Act. A copy of these orders, and corresponding ones pursuant to section 65 of the Act can be found on the Registry file.

- Of the death in custody of **SH** it is noted that their Honour pursuant to section 75 of the Act directed that there be no publication of any material that identifies the deceased person or his family.

In accordance with Premier and Cabinet Memorandum 2009-12 '*Responding to Coronial Recommendations*', I am writing to advise that CSNSW has carefully considered the recommendations and, where appropriate, implemented action. The NSW State Coroner has also received this advice on implementation of coronial recommendations.

Any queries on these matters can be directed to Mr Jeremy Tucker, Chair, Management of the Deaths in Custody Committee, CSNSW on 0436 650 240 or email at jeremy.tucker@dcj.nsw.gov.au.

Sincerely,

14-12-23

Anoulack Chanthivong MP
Minister for Better Regulation and Fair Trading, Minister for Industry and Trade,
Minister for Innovation, Science and Technology, Minister for Building,
Minister for Corrections

Date of finding	Name to be published on the website	Coronial Findings	Recommendations made to:	Recommendation	Supported/Partially supported/Not supported/Under consideration	CSNSW Status November 2023 D23/1368031	CSNSW Formal Response to Attorney General Nov 2023
23-Mar-23	**KT**	Identity The person who died is KT. Date of death: KT died between the night of 8 May 2019 and morning of 9 May 2019. Place of death: KT died at the Metropolitan Remand and Reception Centre, Silverwater. Cause of death: The cause of KT's death is mixed drug (methylamphetamine and clozapine) toxicity. Manner of death: KT died while in lawful custody, after overdosing his prescribed medication, clozapine. The evidence does not establish that he ingested the medication with the intention of ending his life.	CSNSW	1) That consideration be given to a procedure whereby, if an inmate is classified for normal cell placement and has recently experienced a traumatic event in their life, including the death of a family member, Corrective Services NSW consider the appropriateness of their cell placement, and take steps to: a) ask the inmate whether they have a preference to be placed with a cellmate (noting that a range of other factors will also influence the ultimate decision as to cellmate placement), and b) where the inmate is alone, consider whether it is necessary to make observations or otherwise check in on the inmate at reasonable appropriate intervals.	Supported	In Progress	This recommendation is under review
23-Mar-23	**KT**	Identity The person who died is KT. Date of death: KT died between the night of 8 May 2019 and morning of 9 May 2019. Place of death: KT died at the Metropolitan Remand and Reception Centre, Silverwater. Cause of death: The cause of KT's death is mixed drug (methylamphetamine and clozapine) toxicity. Manner of death: KT died while in lawful custody, after overdosing his prescribed medication, clozapine. The evidence does not establish that he ingested the medication with the intention of ending his life.	CSNSW	2) That consideration be given to a procedure whereby the Serious Incident Report author reporting on a death in custody contact the police officer in charge of the investigation, to request updating information as to cause of death, prior to signing off on the Serious Incident Report.	Supported	In Progress	CSNSW are reviewing policies and procedures with a view to implementing the intention of this recommendation, noting that this advice may not be available before the report is due to the court in line with timeframes set out in Coronial Practice note 3.