Submission No 40

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Name: Tracy Mackander

Date Received: 19 August 2021

Submission to the Select Committee on the coronial jurisdiction in New South Wales

Coronial inquest File Number 2019/351386

Bailey Mackander, died on November 5/11/2019

Introduction

I am the mother of Bailey Mackander. On the 5th of November 2019 my 19-year-old son died as a result of what I believe were direct consequences of multiple systemic failures. Bailey was a young Indigenous boy, with many years ahead of him to live. He died while in the care of Corrective Services New South Wales ('**CSNSW**') and Justice Health and Forensic Mental Health Network ('**Justice Health**') services, suffering from deteriorating mental health over a number of days.

Bailey had been placed in an isolation cell the day before his death because he had told a CSNSW psychologist he was struggling to cope in gaol, and had experienced thoughts of self-harm. Although isolation might have been designed to prevent Bailey from seriously harming himself, it did nothing to improve his mental health – in fact, it appeared to make him much worse. While confined in that concrete cell, Bailey was recorded on CCTV and on intercom, pacing, vomiting, gagging, begging and repeatedly pleading "please let me out". He cried that being in that cell was making his anxiety worse, and at times that he could not breathe. Although he had a history of mental health issues, and had asked a number of times to speak to the psychologist, he was told she had "gone home". Bailey was not assessed, at any stage during his isolation, by a mental health professional. He was rebuked by different CSNSW staff including some who told him "there's nothing wrong with you" or threatened to take his 'greens' (prison clothing) from him.

On the day he died, Bailey had been taken to the local hospital from the gaol that he was in, because he said he had swallowed things and was in pain. This was the second day in a row he had to be taken to hospital. Each time, he spent only a short amount of time in the Emergency Department. It was not clearly communicated to the hospital that Bailey was on a self-harm or suicide watch, and no one from the hospital asked about his circumstances in gaol. He was not seen by a mental health nurse or a Psychiatrist at the hospital. He was told he did not need to be admitted, and would be going back to the gaol. Bailey would have known that meant returning to the isolation cell he was so afraid of, with no guarantees about when, if at all, he would be let out.

On the way back to the prison escort van, shackled hands and feet, Bailey took a few short steps towards a wall and leapt over it, to his death.

I believe that Bailey felt his situation was hopeless, and unendurable, because the help and compassion he was crying out for never came. I believe that he thought he had no choice other than to end his life.

The inquest into Bailey's death started at Lidcombe Coroner's Court in April this year. It is not yet finished. I am not going to go through all the details of what seems to have gone wrong

within the health, justice and correction systems, or the pain and suffering that my poor boy went through. Hopefully, at the end of the Inquest into his death, we will have answers. What I will set out to express here is what I have been through, and am still going through, throughout this inquest process.

Getting the Inquest underway

As this was another tragic death in custody, I was immediately thrown into the painful journey of a Coronial inquest. As if it wasn't enough to lose my boy, the inquest process was the start of an ongoing nightmare for me. Nothing could have ever prepared me for what was about to come.

Legal Aid representation

The first real meeting I was asked to participate in with anyone about Bailey's death was with CSNSW. At that stage, I hadn't been referred for any legal advice about the inquest process. I had no idea what my rights were, or who to contact for legal advice. I wanted to know more about the process and was referred to Legal Aid only by chance through conversation with a former client of mine.

I contacted Legal Aid and explained my situation, and was put in contact with one of their civil lawyers. He gave me advice about the whole process, helped me make an application for legal representation, and referred me to the Legal Aid Coronial Unit. Had I not been pointed towards Legal Aid and given that advice, I would have no idea about the process and my options.

My legal team from Legal Aid have been so helpful and supportive from day one – always going out of their way to help me. I can't thank them enough for all that they have done, and are doing, for me and for my son Bailey.

They managed to get the Coroner to expedite the inquest, and get the Crown Solicitor involved early as counsel assisting – in part because they understood the detrimental effects the waiting process was having on my mental and physical health.

I know I would have been lost if I had to go through this process without the knowledge and experience of my lawyers – I don't know how any family, unfamiliar with the inquest process, could advocate for themselves and play a meaningful part in the process without their own legal assistance. I would like to know why families must wait so long for this traumatising process to even get underway, let alone conclude, and why there isn't a clear referral path for legal advice and representation.

Delays in evidence being given to investigating police and the court

When Bailey passed back in November 2019, an Officer in Charge was appointed to investigate the case. He told me back in December 2019 that we could expect to have the brief of evidence by the end of February 2020. I was later advised that statements from

various people from CSNSW, Justice Health and the hospital had not been provided in the time requested, and that some had asked for an extension until the end of May 2020.

Again, the 30th of May 2020 came along, and still no evidence had been provided by the hospital and only a few documents from CSNSW and Justice Health. As far as I understand, the Officer in Charge had no other alternative but to just hand over the evidence he had managed to obtain to the Coroner. It then fell to the Coroner's office to chase the vast number of statements and documentation that was outstanding. From my perspective, it was just one delay after another, and it was truly agonising.

Through the whole Coronial process this delay in statements and documents being provided has been a great challenge for me and my legal team. We would ask for documents over and over, regularly enquiring about when outstanding witness statements were expected. Often, statements and documents we were given just raised further questions – more than once, we identified relevant witnesses who hadn't come forward or even been nominated to give a statement, and had to ask for them to be approached. Despite all the effort and good work by the legal team assisting the Coroner, they were often left waiting like we were, and seemed to be just as frustrated about that.

By the time the inquest finally got to hearing in April 2021, we had a list of many witnesses – including from CSNSW, Justice Health, and NSW Health. Some of those witnesses, 18 months after Bailey died, still had not even provided their written statements. In some cases, we were given the witness statement the day before they were expected to give evidence.

The impact that continual 'last minute service' had on me was terrible – I was in a constant state of suspense, anticipation, and distress. Many witnesses simply stated that, by that stage, they "could not remember" things – that made me angry, because I know if they had given their statements earlier, they might have been able to help us get the answers we are looking for. Other witnesses ended up providing statements that were quite detailed but at the last minute, so it left almost no time to make other inquiries. Often that just led to more questions being raised, and further investigation needing to be done under great time pressure.

The impression I was often left with was that this was a 'tactic' to avoid too many questions being asked, or too much criticism. I felt as though, rather than trying to help the Court find out where *they* went wrong, many witnesses and the organisations they were employed by were more concerned about *protecting themselves* or laying blame elsewhere.

At the moment, the brief of evidence is over 7 volumes large. I have read just about all of it because I want to be involved in this process to get answers for my son. I owe it to Bailey to get answers for him. Each time a new statement or piece of evidence comes though, it's like reliving the whole trauma of losing my son again. It's a nightmare that I can't get out of, made worse because of the delays.

These government departments have had almost two years to submit and lodge their evidence, procedures, policies, and statements. To this day, almost two years since Bailey's death and already halfway through the inquest, we are *still* waiting on documents to be submitted to the Coroner's Court.

I would like to know why these departments are not doing everything in their power to find out, and to tell the Court and families, what exactly went wrong – even if that means accepting that they and their staff could have done better. I would like to know why, when it is a matter of life and death, government departments aren't held accountable for handing over *all documents* that could shed light on how, why, and in what circumstances a person died. I would like to know why there aren't stricter rules for when witnesses have to submit their evidence, and why they aren't held accountable for submitting documents *on time*. This has been an ongoing problem since the beginning when it was in the hands of the police.

I would support the Coroner and counsel assisting having much more power to keep the case on track and to hold parties to account. Most importantly, I would support the Coroner having more power to enforce their findings so that the issues that keep contributing to deaths in custody don't keep happening.

Professional standards

During the inquest hearings, I saw very high levels of professionalism from the Coroner's legal team, my own and others. However, I was also exposed to a few very disappointing behaviours from a few of the so-called 'professional' people we have working in these systems.

More than once, inside the court room, I heard lawyers for other parties laughing, talking about their upcoming holidays, joking about how delays in Bailey's case would cause problems for 'their diary'.

Often, witnesses who played a role in the lead up to my son's death would be sitting across from me, commenting, and snickering amongst themselves, showing no respect for what was going on around them.

There was even an incident that took place downstairs in the only on-site café during one of the breaks. A lawyer for one of the other parties and a witness were caught jokingly 'role playing' what just happened in court. Despite it being such an obviously public space, they seemed not to be aware that an advocate was standing behind them, watching the appalling behaviour unravel. The advocate came and reported what happened, and when confronted about it the lawyer denied it.

What made me feel very disheartened was the lack of awareness and professionalism, and the fact that there was no accountability or reprimand. These are supposed to be professional people with professional standards. I already had issues trusting 'the system' and these government departments, so this made me feel very vulnerable.

Witnesses and lawyers who are involved for other parties should be reminded about the deeply traumatic nature of an inquest for families. They should also understand that the way they choose to conduct their case has a significant impact on families. It has the potential to retraumatise families struggling to navigate the inquest process and to manage their own grief.

There certainly needs to be a clear policy (like the Model Litigant policy) for all these government agencies, their staff, and their lawyers to comply fairly and in accordance with the highest professional standards. After all, Bailey was a human being, not a number and not a statistic. We need to change these systemic failures.

People, and especially government agencies, need to be held accountable for providing all the evidence they have that could assist the Coroner to find answers, not just sitting back waiting to be asked for it. There should also be real accountability for failing to cooperate in seeking out truth.

Court support services

In my experience, there is a real lack of support and counselling services through the Coroner's Court.

Bailey's case involved CCTV including parts that showed his confinement in an isolation cell, and his horrific fall to his death. I chose not to view it myself because I felt it would be too distressing for me. About a month before the inquest was about to begin, my solicitor contacted the Coronial Information and Support Program ('**CISP**') to request that they assist in me viewing it.

I understand that CISP are a small group of social workers who have experience with the inquest process, and can provide support to next of kin in viewing that kind of sensitive evidence. However, CISP does not provide any ongoing counselling support to families. They also do not assist with accommodation or witness expenses, which in my case was arranged for me via my solicitors. Although the complex at Lidcombe is new, is very tidy, and has small meeting rooms, there is no dedicated 'family room' for relatives attending inquests at the Lidcombe Coroner's Court to sit quietly away from everyone else with simply things like a fridge, microwave and water. Although I could barely eat throughout the hearing days, there is only one café on site, which not everyone can afford to buy from day after day anyway.

I had a phone call from a support person from CISP a few weeks before Bailey's inquest was about to start. She began to explain the process of how they would help me get through the sensitive CCTV footage. This was supposed to prepare me for what was going to be played in open court as evidence. What disturbed me was they wanted me to be at the Coroner's Court at 8am on the first day of the inquest, to view the footage before court started. I had never been to the Coroner's Court, and am not from Sydney. I was going to have to travel down in the days beforehand and stay in a hotel on my own. I was already nervous, not knowing what I was about to walk into. I could not imagine, on top of that anxiety and fear, sitting down to view Bailey's last moments, with a person I had never met, right before the start of the first hearing day.

It should have been an option for me to have this support a few weeks before I was to appear in court – not on the first day. Surely there must be some way of conducting this process other than how this was delivered to me. I know now that if I had seen this footage immediately before the hearing started, I would never have made it into the court room.

For families that are in this foreign court environment it becomes a very overwhelming experience. There were times where I felt as though I would never make it through. The Coroner in Bailey's case has been so kind, and careful to check in on me throughout the hearing. There is only so much she can do though – the process still must unfold, and it is reliant on so many other people doing their jobs well.

I have had to rely on myself, my lawyers, and advocates who often turn up at court for emotional support. I sit there in court each day, knowing my life will never be the same again, riddled with sadness and grief for my boy.

In the end, I chose not to access further CISP services because of that initial experience. If support services for families were better resourced at the Coroner's Court I imagine they would have been able to *proactively* reach out to me months or weeks before the inquest to explain what they could offer, and to build rapport with me. This would have given me more confidence in accessing that service during the hearing.

It would have helped also to have dedicated counselling services present at court to assist with referrals for ongoing trauma support, and to help me process at the end of each day and prepare for the next.

The impact of court processes on the grieving process

I have not been able to move on, or allowed myself properly to grieve since Bailey died. I have felt as though I had to stay strong and be as closely involved as possible for Bailey's sake and his memory.

I have gone to meetings with CSNSW and Justice Health, listened to their representatives express their condolences while at the same time trying to avoid expressing anything that might sound like acceptance of organisational responsibility. I have gone to meetings with my lawyers, read almost every part of the brief of evidence, attended every court date, and I continue to wait for answers to the many questions I have. I have thrown myself into this horrible process because I owe it to my son to get answers for him.

It has almost been two years since the passing of Bailey. It has been an emotional, soul-destroying journey since his death. Although the inquest into Bailey's death started in April 2021 we are still only halfway there. The case had to be adjourned for further hearing days this October. While I want the process to be as in-depth and critical as possible, the waiting is torture, and it has taken a significant toll on my mental health and emotional wellbeing.

I know how much of an effect it has had on me waiting this long, and I know many families wait even longer than I have. I cannot even imagine how difficult it must be for them knowing how hard it has been for me so far.

Before Bailey died, I was fit and active and had no mental health issues. As a result of the trauma of Bailey's death, I have been diagnosed with Post Traumatic Stress Disorder ('**PTSD**'), depression and anxiety, and social phobia disorder. I received no offer of counselling or

treatment through the Coroner's Court. Although CSNSW agreed to fund 10 sessions with a psychologist not long after Bailey died, it was left to me to find the psychologist. I found someone who specialised in grief and trauma and at the end of the first 10 sessions, she wrote to CSNSW recommending further treatment funding, but this was declined.

I am now under the care of that same psychologist and a psychiatrist. I am out of pocket for that ongoing care, and medication to help me cope. I have not been able to start properly dealing with my trauma because I am still in the depths of the inquest and am not ready. It takes too much energy just to try and 'keep it together' and to stop myself from falling to pieces while I am on the long road to getting answers and accountability. The pressure involved in going through this unfamiliar court process is overwhelming, and the constant addition of further statements and more documents escalates my anxiety. I have had to put my own grief and healing on hold to get through.

I cannot embark on the process of grieving while this inquest hangs over me, and until I get closure for Bailey.

I am willing to speak to members of this Inquiry if it would assist in any way.

Sincerely,
Tracy Mackander