QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stuart Cecil FORD**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/213
DELIVERED ON:	6 March 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	22 November 2011, 7 - 8 February 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, suicide

REPRESENTATION:

Counsel Assisting:	Mr Chris Minnery
Department of Community Safety:	Ms Kay Philipson
Queensland Health:	Mr Kevin Parrott

Table of Contents

The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Stuart Cecil Ford. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of State Coroner.

Introduction

When he died, Mr Ford was in custody at the Wolston Correctional Centre (WCC). At 7:30am on 16 January 2010, the doors of the cells were opened but Mr Ford did not come out and stand by the door as did the other prisoners and as was required. A prisoner looked into the cell and upon seeing Mr Ford with a plastic bag over his head, called for assistance.

Unfortunately, CPR attempts by correctional staff and Queensland Ambulance Service (QAS) officers were unsuccessful.

These findings:

- Confirm the identity of the deceased, determine how he died and the date, place and medical cause of his death as required by s. 45(2) of the Act;

- Critique the adequacy of the mental health care provided to the deceased while he was in custody in the months leading up to his death; and

- Consider whether the access of paramedics to the prisoner when he was found unconscious was impeded by security.

The investigation

Mr Ford's death was reported to the Corrective Services Investigation Unit (CSIU) and the investigation carried out by Plain Clothes Senior Constable (PCSC) Tiffany Roache.

To assist in resuscitation attempts QAS officers moved Mr Ford out of his cell. Once life extinct was declared by the QAS officers Mr Ford's body was returned to his cell and locked. PCSC Roache attended the WCC with other CSIU officers at about 10:15am and made arrangements for the attendance of QPS forensics and photographic officers. I am content that the integrity of evidence at the scene was maintained.

The QPS forensic officers conducted a thorough examination of Mr Ford's cell. Letters apparently written by him were taken from the cell for further analysis.

All records relating to Mr Ford were seized from WCC together with rosters, transfer forms and plans relating to the unit where he was accommodated. Medical records from WCC, including psychiatric records were also obtained.

Statements were obtained from corrective service officers (CSO's), medical staff and the psychiatrist who last saw Mr Ford. Other prisoners in Unit were spoken to by the CSIU officers.

Records of Honeywell Security were obtained and showed that the cell door was not opened between lock down on Friday 15 January 2010 and unlock on Saturday 16 January 2010.

Mr Ford's body was transported to Queensland Forensic and Scientific Services where a post mortem examination was conducted on 19 January 2010. A blood sample was taken and underwent toxicological testing.

The Office of the Chief Inspector, Queensland Corrective Services (QCS) commissioned a separate investigation and report into the circumstances surrounding the death of Mr Ford. That report was tendered at the inquest.

In addition to the material compiled by the CSIU and investigators appointed by QCS, Counsel Assisting sought a statement from WCC detailing what, if any, action had been taken in response to the recommendations made by the investigators appointed by QCS.

I am satisfied all relevant material has been produced to the court and find the investigation into this matter was thoroughly and professionally conducted. I commend PCSC Roache for her endeavours.

The inquest

A pre-inquest conference was held in Brisbane on 22 November 2011. Mr Johns was appointed Counsel Assisting. Leave to appear was granted to Queensland Health and the Department of Community Safety.

An inquest was held in Brisbane on 7 February 2012. It heard from seven witnesses. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Useful submissions were given on 8 February 2012.

The evidence

I now turn to the evidence. Of course I cannot summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in this report a summary of the evidence I believe is necessary to understand the findings I have made.

Social history

Mr Ford was born on 9 September 1953 in Newcastle, New South Wales. Both his parents passed away in the period 2003 to 2004. He had one younger sister, Natalie, who resides in Sydney but it seems he had limited contact with her, at least since his imprisonment.

It seems the deceased had a close relationship with his father, but had a strained relationship with his mother.

After leaving school he gained work in the cinema industry, screening movies, particularly in remote areas. He also worked as an announcer in shopping centres.

Correctional history

At the time of his death, Mr Ford was serving a term of imprisonment in relation to offences of sexual assault, breach of bail, dangerous operation of a motor vehicle, unlawful sodomy and assault occasioning bodily harm, as well as an activated suspended sentence originally imposed in relation to indecent treatment of children.

He was taken into custody in the Townsville Correctional Centre on 15 April 2004 and he was transferred to the Wolston Correctional Centre on 16 July 2006. At the time of his death, Mr Ford was in the process of again applying for parole.

Background

At the time of his death, Mr Ford was housed in cell 1 of unit S8, a secure unit containing fifty cells, a common area and an exercise yard. CSO Robinson said in evidence that the unit tends to be used for prisoners with mental health issues, or with greater needs, or with other issues requiring particularly high staff supervision.

He had a job in the laundry at the prison. It was a position he valued highly but there were difficulties with it in the weeks before his death.

On 3 January 2010 Mr Ford was spoken to by a CSO about complaints he was not finishing allotted tasks in the time allowed.

On 11 January 2010 he was spoken to by a counsellor, Mr Alexis, and he indicated the pressure of the job was stressing him, due to prisoners wanting work done in a short period of time.

On the day prior to his death, 15 January 2010, at about at 2:30pm, Mr Ford was informed he was suspended from his position as laundry worker because of complaints about him charging other prisoners to do their laundry and his interfering with clothes driers to make them dry faster. He denied the first complaint but admitted the second, claiming he had been told by an electrician that what he had done would cause no harm.

Mr Ford was informed that he was suspended for his job, rather than terminated, because CSO Veltheim "*knew how he would carry on when he found out he was sacked*." He was also informed that he was to be *"breached*". This was a reference to administrative proceedings that are brought against a prisoner when it is alleged he has failed to comply with some regulation or direction.

CSO Veltheim observed Mr Ford to be visibly upset at this news – his voice was shaking and he appeared about to cry. He went away, to his cell or the common area.

At 3:06pm he called the Judicial Review Assistance service, which, as its name suggests, assists prisoners with parole applications and reviews. Mr Ford advised the person he spoke to that he had been breached and asked how it might effect his pending parole application. He was told to call back in the morning to speak with a more senior staff member. On the automatic tape recording of the conversation Mr Ford can be heard to reply "*if I'm still here*." The person he was speaking to said she did not recall or did not hear this final remark.

At about 3:50pm, Mr Ford approached the officers' station and asked to see a counsellor, Mr Alexis. Mr Alexis was summoned and spoke with the prisoner for about 30 to 45 minutes. He recalled Mr Ford was concerned and stressed about the

likelihood he would lose his job. He also discussed moving from the secure unit to the residential unit, and his future parole application. Mr Alexis acknowledged that Mr Ford was upset but said he was quite future oriented. The deceased reported no suicidal thoughts or indications that he was considering self-harm to Mr Alexis, something the counsellor said he had been trained to be alert to.

Graeme Hancock, another S8 prisoner, had contact with Mr Ford on a number of occasions on the day in question. When he spoke with him at about 5:00 or 5:30pm the deceased was extremely emotional about losing his job. He said; "*I'm sick and tired of all the bullshit that goes on in this unit in regard people writing blue letters about different people."* (A blue letter is a letter directed to the general manager of the prison.)

At about 6:10pm, just before the prisoners were locked away for the night, Mr Ford spoke to a prisoner Rose and told him about losing his laundry job indicatinging that *"if they want the job they can have it."*

Shortly after the prisoners were locked away for the night, CSO Veltheim served the deceased with papers in relation to the breach proceedings. Mr Ford asked how those proceedings might affect his parole. CSO Veltheim informed him "*don't worry, it will probably only be a minor and you'll only get a slap over the wrist*." The prison officer said Mr Ford appeared to be happy with this and said good night to CSO Veltheim as she closed his door.

Headcounts were performed throughout the night at 8:40pm, 12:58am and 4:25am. No incidents were reported, and none of the prisoners in unit S8 reported hearing anything out of the ordinary when later interviewed. Prisoner Rose, who resided in the cell next to the deceased, recalled not hearing the usual noises he would hear from the deceased's cell during the early morning (showering, the radio, moving about) but didn't think anything of it, and didn't hear any unusual noises.

No CCTV cameras record the entrance to the deceased's cell on a continual basis – the cameras are activated in response to an incident. Electronic data collected by the door locking system indicates that the door was not opened from lockdown until the following morning.

The death is discovered

At about 7:10am, CSOs Stephen Robinson and Irvin Black entered the unit and commenced a headcount. CSO Robinson said he looked into Mr Ford's cell, and saw him lying on his back with his head towards the door. He said in his statement and in his evidence that he saw movement of the deceased's chest indicating he was breathing. There was nothing over the deceased's head. CSO Robinson recalled seeing Mr Ford had his hands crossed over his stomach and movement in his eyes and chest. He continued with the headcount. Once he completed the head count he reported over his radio that all prisoners were accounted for. When the officers doing the same in other cell blocks also made their reports all cells were unlocked from a central control point. This occurred at 7:30.

After the cells are unlocked, the prisoners are required to come out and stand by the doors. CSO Robinson noted that Mr Ford had not come out of his cell. He started to walk towards cell 1; as he did so prisoner Rose looked into the cell and called out; "*He has a bag over his head*."

CSO Robinson entered the cell and saw the occupant lying in the same position as he had seen him earlier, except he now had a green plastic garbage bag over his head. Mr Robinson immediately pulled the plastic bag off and he felt a gush of warm air on his hands. In his evidence, CSO Robinson indicated that at first he thought the prisoner was just *"carrying on*". However, when Mr Ford remained unresponsive CSO Robinson called out to his colleague, CSO Black, to call a code blue, while he put the prisoner in the recovery position. He checked for a pulse and respiration and did not find either, although he noted Mr Ford's body was still warm.

Emergency response

When CSO Black broadcast over his radio a code blue – a medical emergency – four CSOs and a supervisor responded. Two nurses from the medical unit also attended, bringing with them a resuscitation trolley.

The deceased was moved to the floor to better facilitate resuscitation. He was unresponsive, and his ears and lips were cyanotic. His face was pale, he was warm to touch, he had no palpable carotid pulse, he was not breathing and his pupils were fixed and dilated. Manual resuscitation attempts commenced.

Queensland Ambulance Service staff were called and attended. Mr Ford was moved out of the cell to give better access for resuscitation. The first responding QAS officers, Nathan Orford and Rodney Sharpe arrived at 7:50am.

At 7:55 am, Mr Ford was declared dead by the QAS personnel and resuscitation efforts ceased. His body was moved back into the cell, and the cell locked until the police arrived.

Autopsy findings

Mr Ford's body was taken to the Queensland Health Scientific Services facility at Coopers Plains for autopsy.

An autopsy was undertaken by an experienced forensic pathologist Dr Beng Ong. His findings were consistent with death by plastic bag asphyxia. This mechanism of death does produce diagnostically definitive features, so this is essentially a negative post-mortem finding – that is, there was nothing found at autopsy that was inconsistent with self inflicted asphyxiation or that suggested some other manner of death. The deceased had the expected levels of therapeutic drugs in his blood. There were no unusual findings.

Fingerprint, handwriting and witnesses

A search of the cell revealed a number of letters in envelopes torn up and placed in the cell bin, and papers on the cell desk. A number of diaries were also located. The handwriting was that of the deceased and only his fingerprints were found in the cell.

In the 2010 diary was an entry on 15 January 2010, indicating that the deceased had been suspended from his laundry job; he had seen the counsellor; and he had rung the Judicial Review Assistance service. The entry also noted Mr Ford had been told he was being breached on issues relating to the washing machine tampering. The entry continues "*given breach paper at 1810 by Di Veltheim. FINAL TRIGGER.*"

Forty-eight prisoners from unit S8 were interviewed. No information was received indicating that any person other than Mr Ford had been directly involved in his death.

Complaints

The letters found in the cell were addressed to prison officials and other prisoners. The allegations in them were investigated. The details are as follows.

A letter to Sharon McCallum-Clark, the General Manager of the WCC, indicated the deceased's dissatisfaction with the treatment of his mental illness and his dissatisfaction with the fact that his stereo was not returned to him.

A letter to prisoner Hancock included reference to being sorry that the deceased did not say goodbye, and that "*today's events went further than I can cope with*."

A letter to intelligence analyst Thirkle provided intelligence into illicit prison activities, such as the sale of Tramal and corrupt activities in the prison store, and said "*such a pity that you did not speak with me when I asked a few days ago*."

A letter to Mr Alexis indicated the deceased had made up his mind to end his life before seeing Mr Alexis on 15 January 2010, and that he had known for a very long time that "*this course of action was inevitable*." The writer also indicated that his death would "*blow the dysfunctional mis-management with all its corruption wide open for full investigation*."

During the autopsy, a letter addressed to the State Coroner was located between the two pairs of underwear that the deceased was wearing, folded up and sealed in plastic. In it Mr Ford entreats a thorough examination of all the indignities he has suffered in WCC and elsewhere. He refers to Mr Peter Nesbitt (of Judicial Review Assistance) as having full details of the "*negligence and corrupt conduct* "inflicted upon the deceased, particularly by sentence management. He also refers to the blithe acceptance by "*management*" of unfounded allegations against the deceased in relation to his employment, and this being "*the final trigger*". He also refers to occasions upon which he had been bullied by other prisoners, occasions in the two months prior to his death in which he has been denied access to counsellor Mr Alexis, and the "*negligent*" extraction of his teeth denying him a future career as a radio announcer in the north of Australia.

Mr Peter Nesbitt provided a statement in which he denied he has details of all the "*negligence and corrupt conduct inflicted on (the deceased) by Wolston management*." Such material was never supplied to him, although he does have the full parole applications of the deceased.

The General Manager indicated in her statement and her evidence at the inquest that she was unaware of any allegation of corrupt conduct by any of her staff towards the deceased. No such conduct was uncovered by a thorough police investigation. There was no complaint to the CMC or to the Minister for Police and Corrective Services. The deceased was known to raise matters constantly but had never raised with her, or raised in a way that was brought to her attention, corruption or misconduct within the prison. In her position as general manager she would expect to be promptly informed of any such allegation.

Relevant to the allegation that he was bullied, some evidence was heard at the inquest of negative verbal interaction between the deceased and prisoner Radan. However this was more in the nature of snide comments by each of the deceased and prisoner Radan at each other. There was no suggestion of physical violence or harassment and no such complaints had ever been raised with the General Manager, although there was some discussion about it with Mr Alexis, the unit counsellor.

The claim that there was restriction on Mr Ford's access to the unit counsellor, Mr Alexis is not supported by any evidence. Mr Alexis visited the unit every day in the course of his duties. The deceased availed himself of the opportunity to see Mr Alexis on a daily basis or at most, every few days. The deceased was accommodated by Mr Alexis whenever possible, although on occasion he was asked to wait until Mr Alexis had finished with other prisoners. All staff in a position to report on the issue, including Mr Alexis, indicated that the deceased was never restricted in his access to the counsellor.

The deceased complained of the loss of future prospects, stemming from issues with his dental treatment and his dentures. Mr Ford's problems with his teeth stemmed from bruxism – grinding of the teeth. This led to hypersensitivity. It was responded to by the construction of full upper and lower dentures. They were fitted on 2 April 2009. Following this Mr Ford complained of problems with particularly the lower denture – he was at one stage convinced that the roots of the removed teeth were left behind, although this was not confirmed by X-Rays. He had several visits to adjust the dentures. They were re-aligned. Issues persisted, and the clinic was in the process of referring the deceased to the maxillo-facial department of the Princess Alexandra Hospital when he passed away.

I am satisfied that none of the allegations has substance. The complaints articulated by Mr Ford are best viewed in light of his mental illness that is referred to below.

Documents located in Mr Ford's cell also indicated who was to be informed of his death, the distribution of his prison assets, and his New South Wales solicitor who could be contacted for his last will and testament.

Stressors acting on the deceased

Mr Ford was also stressed by a number of other matters, namely: he was concerned that he may have been about to be the subject of an application pursuant to the *Dangerous Prisoners (Sexual Offenders) Act;* he was involved in litigation in relation to his deceased father's estate; and the loss of laundry job obviously weighed heavily on him.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings.

Identity	The deceased person was Stuart Cecil Ford
How he died	Mr Ford intentionally took his own life by placing a plastic bag over his head whilst a prisoner serving a custodial sentence in the Wolston Correctional Centre
Place of death	He died at Wolston in Queensland.
Date of death	Mr Ford died on 16 January 2010.
Cause of death	He died from asphyxia

Comments and recommendations

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. The issues which may warrant consideration from that perspective in this case are:-

- Assessing and responding to the prisoner's risk of self harm;
- Limiting access to dangerous items; and
- Timely access for emergency assistance.

Risk management

From soon after his initial reception at the Townsville Correctional Centre, Mr Ford was recognised as a prisoner with an elevated base line risk of self harm. The relevant prison staff at WCC were aware that he had previously attempted suicide and that from time to time he articulated suicidal ideation.

In my view appropriate steps were taken to manage that risk.

Soon after Mr Ford came into custody he was reviewed by a psychiatrist, a Dr James, who diagnosed him as "*suffering from an adjustment disorder with anxiety and depressed mood that is of some severity*." Dr James recommended he be located in the prison where there was some personal compatibility between the deceased and his fellow inmates, some meaningful occupation, and the opportunity for some supportive psychotherapy, with assurance of continuity of therapist.

Those recommendations were largely implemented.

At the WCC Mr Ford was seen by psychiatrist Dr Evelyn Timmins from 16 March 2009 through to the date of his death. Prior to her taking over as his treating psychiatrist Dr Peter Fama was in the role.

Mr Ford was appropriately medicated with anti anxiety drugs, mood stabilisers and sleeping tablets. His medication regime was adjusted regularly, as a result of concerns expressed by him.

From 2006, the deceased was seen by the same counsellor, Mr Job Alexis, resulting in an unusually high level of continuity of care. Mr Ford had nearly daily access to him.

There existed a process for notification of negative events that might increase a prisoner's risk of self harm such as the death of a family member, but it was not formally activated in relation to Mr Ford in the days before his death. As we now know the various stressors impacting on Mr Ford seem to have had a cumulative effect but it does not follow that the prison authorities ought to have anticipated this. I am satisfied that Mr Ford's extreme reaction to his circumstances could not have been foreseen and that by giving him regular access to a counsellor and a psychiatrist, the correctional centre management did all that was reasonable to care for him.

All relevant staff members were trained to recognise risk of self harm and none were apparent in this case at the relevant time. He had made no threats of self harm since September 2009.

I am of the view there is no basis to criticise the risk assessment process as it applied to Mr Ford or to recommend any changes to it.

Dangerous items

This case shows it is not possible to identify all prisoners who are at acute risk of self harm. Therefore, it is important to minimise access to means of self harm as an extra safeguard.

Since Mr Ford's death that has been advanced by severely restricting the availability of plastic bags within the secure unit. They are no longer routinely issued as bin liners. The evidence from all corrective services staff who gave evidence was that the plastic bag ban has been thoroughly implemented.

Emergency access

There was a suggestion that QAS access had been unduly hindered. The notes on the QAS file indicate that there was a problem getting through security:

> *Due to getting through security gates at the correctional facility it was more than 20 minutes before QAS arrived and on arrival CPR in a very cramped cell was ineffective, patient mottled and grey in colour and QAS decided to drag patient out to continue assessment*

The call to the QAS was received at 7:37am. A unit was dispatched at 7:38am, and was coded as being on the way (en route) at 7:39am. The unit was on scene at 7:51am and at the patient at 7:51am. Therefore, according to QAS records, the interval between the departure of the QAS unit and the paramedics arriving at the patient was about twelve minutes. The note in the QAS report about a twenty minute delay must be incorrect.

I conclude the circumstances of this case provide no opportunity for preventative comments or recommendations.

I close this inquest

Michael Barnes
State Coroner
Brisbane
6 March 2012