QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Scott Matthew O'Connor**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2013/273
DELIVERED ON:	14 August 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	22 May; 20 July–24 July 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; hanging; maximum security unit; supervision of prisoners; prison mental health services.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Ulrike Fortescue (Department of Justice and Attorney-General)
West Moreton Hospital and Health Service:	Mr Chris Fitzpatrick (i/b WMHHS)
GEO Group Australia Pty Ltd:	Mr Stephen Zillman (i/b Ashurst Lawyers)
The O'Connor family:	Ms Kylie Hillard (i/b Fisher Dore Lawyers)
Ms Gaylene Scarfe:	Ms Sally Robb (i/b Roberts and Kane Solicitors)

Table of Contents

Introduction

Scott Matthew O'Connor was 31 years of age when he died in the maximum security unit (MSU) of the Arthur Gorrie Correctional Centre (AGCC) on 22 January 2013.

Mr O'Connor was being held in the MSU's Detention Unit. This unit had two cells which were both equipped with a lockable exercise yard attached to the cell. Mr O'Connor's access to the exercise yard was not restricted. Just after 3:30pm on 22 January 2013, an unsuccessful attempt was made to contact him via his cell intercom. He could not be seen from the cell camera, leading correctional staff to believe that he was in the exercise yard. He could not be seen from the exercise yard's CCTV camera, as he had covered this the previous day.

A code yellow and a code blue were called and entry was gained to the cell. Officers went into the exercise yard where they found Mr O'Connor hanging from the mesh roof frame, a short distance from the CCTV camera. He was cut down and QAS paramedics attended. However; he was unable to be resuscitated and was pronounced deceased at the scene.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;

- Consider the adequacy of the mental health treatment provided to the deceased in the lead up to his death, and whether a referral to the Prison Mental Health Service should have been made earlier;

- Consider the adequacy of the decisions made with respect to the continuation of the At Risk Management Plan the day before the death;

- Consider the adequacy of the observations of the deceased in his cell on the day of his death; and

- Consider the adequacy of the response by Arthur Gorrie Correctional Centre to the recommendations made as a result of the investigations conducted by the QPS, GEO and the Chief Inspector.

The Investigation

Investigations were conducted into the circumstances leading to Mr O'Connor's death by the following agencies:

1. The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU);
2. The Office of the Chief Inspector (OCI) Queensland Corrective Services; and
3. The GEO Group Australia Pty Ltd, operator of the AGCC.

The QPS investigation was led by Detective Senior Constable Brendan Anderson. He submitted a report to my Office which was tendered at the inquest.

Detective Senior Constable Anderson attended AGCC with several other CSIU officers. He inspected the MSU and oversaw the forensic examination of all points of interest. Mr O'Connor had been isolated and AGCC staff had appropriately photographed the scene.

CSIU officers commenced the process of taking statements from staff and inmates of the MSU. They took steps to seize all relevant records and interrogated the AGCC Information and Offender Management System (IOMS). Detective Senior Constable Anderson spoke to intelligence officers at AGCC and made arrangements for statements to be obtained from senior officials at the prison. He also seized CCTV footage of the cell where Mr O'Connor was being held. Scenes of crime officers also took a series of photographs of the scene.

The Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by s 294 of the *Corrective Services Act* 2006. Those investigators prepared a detailed and thorough report which was submitted to the Office of the Chief Inspector (OCI Report). It examined matters within and beyond the scope of the coronial inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings.

I also had access to a report compiled by an investigator appointed by the GEO Group Australia Pty Ltd, the private company which operates AGCC.

I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

A pre-inquest conference was held in Brisbane on 22 May 2015. Miss Cooper was appointed as counsel assisting and leave to appear was granted to Queensland Corrective Services, the GEO Group Australia Pty Ltd, West Moreton Hospital and Health Service (WMHHS), Mr O'Connor's family and Nurse Gaylene Scarfe.

An inquest was held from 20–24 July 2015. All of the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigations were tendered at the inquest. Oral submissions were heard from the represented parties following the conclusion of the evidence.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

Scott O'Connor had an extensive criminal history. At the time of his death, he was on remand for the alleged murder of a fellow prisoner. That incident occurred on 27 December 2011 and was the subject of a separate inquest.[1] He was serving his eighth period of imprisonment. Prior to being charged with murder, he had been on remand since 21 December 2010 on charges of armed robbery.

Mr O'Connor had been held in the AGCC Detention Unit on consecutive safety orders up to December 2011. He was then transferred to the MSU on a maximum security order as a consequence of his role in the violent death of Kyle Canisi. Safety orders were maintained in the MSU.

The former General Manager of the AGCC, Greg Howden, described Mr O'Connor as "one of the most difficult prisoners I had to manage in my 38 year career in corrective services". The inquest heard evidence about Mr O'Connor's time at AGCC, and various safety orders which were imposed on him to manage the violent and dangerous conduct he had demonstrated to correctional staff and other prisoners. He was regarded as an unpredictable and physically imposing prisoner – he was 194cm and weighed 94kg at the time of his death.

Mr O'Connor also had a history of self-harm at other correctional facilities. The safety order was renewed every 28 days, and included conditions that he be accommodated at a cell in the detention unit and that he have no association with any other prisoner unless with the permission of the General Manager.

Mr O'Connor was survived by his parents and a young daughter. His parents endeavoured to maintain contact with him while he was imprisoned and attended the inquest. They were obviously distressed by the circumstances of his death. I offer them my sincere condolences.

Mental Health History

Mr O'Connor was an intermittent patient with the Prison Mental Health Service (PMHS) from 2000-2012. However, he had never been placed on orders under the *Mental Health Act 2000*. He had a history of non-compliance with respect to his medication.

The PMHS file was tendered and showed that Mr O'Connor had previously been diagnosed with schizoaffective disorder, bipolar affective disorder, anti-social personality disorder, intellectual impairment (in terms of a borderline IQ)

[1] Findings into the death of Kyle Leslie Canisi, delivered 17 December 2014

and a history of substance abuse including alcohol, amphetamine, cannabis and various opiates.

Mr O'Connor's last appointment with the PMHS was on 2 February 2012. Following Mr Canisi's death in December 2011 he had been reviewed on several occasions by Dr Russ Scott, psychiatrist, and Dr Andrew Aboud, the Clinical Director of the PMHS. Neither doctor identified a need for any acute intervention at that time. There was no evidence of an active mental illness and Mr O'Connor was discharged from the PMHS in February 2012.

As discussed below, while a referral had been made to the PMHS on the day before his death, he was awaiting assessment and was not a client of the PMHS at the time of his death.

Management of Mr O'Connor from 18 – 21 January 2013

There were issues with Mr O'Connor's medication compliance in September 2012 when he also "completely trashed his cell". At this time a "notification of concern" was raised. When interviewed, Mr O'Connor stated that he would "be out of the unit by Christmas meeting the big bloke upstairs and staring him in the eyes". On 25 September 2012, he was assessed as being at low risk of self-harm by psychologist, Hanah Walton, and placed on 120 minute observations. On 23 October 2012 it was decided that observations could cease.

The inquest heard evidence that from mid-October 2012 to January 2013 there were few recorded issues involving Mr O'Connor. By 15 January 2013, he had refused all medication except tramadol. He was covering the camera in his cell and refusing to remove the cover. His mental state appeared to rapidly deteriorate after this time.

Over the course of the night shift on 17 January 2013, concern was raised about Mr O'Connor's behaviour by custodial corrections staff. His mood was flat and he was pacing and not sleeping. This was communicated to MSU Supervisor Dylan Mareales (also currently known as Keith) when he started work on the morning of 18 January 2013.

These concerns were escalated to the General Manager, Mr Howden. It was apparent that Mr O'Connor was wanting to see a psychiatrist. He was also wanting to give away his pet bird and was reported as saying that he did not want it anymore. This request was particularly concerning to Mr Howden because Mr O'Connor had gone to considerable effort to initially prove that he should have the care of the bird and then to train it.

Mr O'Connor's request to see a psychiatrist proceeded through a number of staff at the prison. Ms Hanah Walton made contact with Mr Mareales and a mental health nurse, Gaylene Scarfe. Ms Walton ascertained that Mr O'Connor was only prepared to see a psychiatrist, not a psychologist. Dr Neale was the duty psychiatrist at the prison on 18 January 2013. He was fully booked and could not see Mr O'Connor.

At Mr Howden's request, Prison Services Manager, Sue Noordink, and the Health Services Manager, Shirley Sheppard, went to see Mr O'Connor. Ms Noordink was successful in engaging in a conversation with him. Following this a "notification of concern" was raised and he was placed on a 30 minute observations regime. This meant he was assessed at high risk of harm to himself. The observations were to be both visual (via CCTV) and physical (he was to be sighted in person).

At the inquest Ms Sheppard confirmed that, while the PMHS was consulted over the course of 18 January 2013, there was no formal referral made to that service at the time. The PMHS was given a 'heads up' about Mr O'Connor's case, and was advised that prison staff would continue to monitor the situation over the course of the weekend.

Over the weekend of 19-20 January 2013, the majority of the AGCC staff involved with Mr O'Connor the previous day were not on duty. A mental health nurse, Frikkie Botha, was rostered on and, at the request of Nurse Scarfe, he spoke to Mr O'Connor on both days. I heard evidence from Nurse Botha at the inquest. He was unable to recall significant detail about what had occurred on 18 January 2013. He was aware that an observations regime was in place, but was not aware of the behaviours exhibited and things said by Mr O'Connor that gave rise to the notice of concern.

On 19 January 2013, Nurse Botha had a conversation with Mr O'Connor, the substance of which was captured in the Offender Health Records. During that conversation it was noted that Mr O'Connor –

- was bright and reactive and said he was going to turn his life around – he had found God;
- could hear the voice of his victim's father in a car and he found that distressing – he could talk back to the voice and he got some answers; and
- said he was "cold" inside.

Nurse Botha noted that, despite these comments, Mr O'Connor displayed normal emotions and there were no clinical signs of depression. It was agreed that Nurse Botha would return the next day and speak further with Mr O'Connor. Nurse Botha's evidence was that it was not unusual for prisoners to hear the voices of their victims.

On Sunday, 20 January 2013, Nurse Botha had another conversation with Mr O'Connor. Mr O'Connor said that he could not recall the conversation the previous day or in fact who Nurse Botha was. When asked at the inquest about whether this was at all concerning, Nurse Botha said in his view that this was not unusual.

Nurse Botha gave evidence that the purpose of the conversation on 20 January 2013 was to compile an assessment report for the Risk Assessment Team (RAT) meeting which was to be held the next day. The substance of Nurse Botha's conversation with Mr O'Connor was again captured in the

Offender Health Records. During that conversation it was noted that Mr O'Connor was hearing the voice of the victim's father and was seeking forgiveness.

Nurse Botha recommended to the RAT team that Mr O'Connor be maintained on 30 minute observations, assessing that he remained at a high risk of harming himself.

By Monday, 21 January 2013 Mr O'Connor was still refusing his medication. Ms Walton gave evidence at the inquest that she spoke with Mr O'Connor at length that morning for the purposes of conducting an assessment of his risk for the RAT meeting to be held at lunchtime.

Ms Walton gave evidence that while there were concerning features of his presentation, she also identified a number of protective factors which in her view supported that he be maintained on 30 minute observations. Ms Walton gave evidence that she included the most serious information in her recommendations section of the report, so as to support her view that Mr O'Connor be maintained on 30 minute observations. Ms Walton acknowledged that she did not have regard to Nurse Botha's notes from the weekend when conducting her assessment. She said that the information from Mr Botha would not have resulted in her elevating the assessed level of risk. She did have regard to the notification of concern and initial assessment from 18 January 2013.

At the inquest I heard a considerable amount of evidence about the RAT meeting which was held at about lunchtime on 21 January 2013. The purpose of this meeting was to assess prisoners at risk of self-harm and develop a plan to manage the assessed risk.

The RAT is a multidisciplinary team and receives contributions from a mental health nurse, psychologist and correctional officers. The meeting is chaired so as to provide an independent perspective on the material provided. The decision of the chairperson is required to be ratified to provide a further review of the meeting outcomes.

It was confirmed that the chairperson of this particular meeting was Ms Sheppard, and the ratifier was Ms Noordink. Their evidence was to the effect that they relied on the assessment reports provided by Nurse Botha and Ms Walton with respect to Mr O'Connor's level of risk.

Evidence was provided that while Ms Walton compiled the psychological report, it was presented at the meeting by another psychologist, Elana Carr. Similarly, while Nurse Botha compiled the mental health nurse report, Ms Scarfe attended the meeting on his behalf.

I also heard evidence from Correctional Services Officer Roy Slade that he attended the meeting on behalf of correctional officers. However, he had not worked in the MSU since 2005. He was not given a corrections report for the meeting. Although he tried to obtain the report, he said it was not provided before the meeting had concluded.

The evidence at the inquest surrounding what occurred at the RAT meeting, and what matters were discussed, was not clear. A document was produced which purports to be the minutes of that meeting. However, it is clear that the document merely duplicates the information contained in the respective reports produced to the meeting. The minutes do not reflect any analysis of this material or any discussion that might have taken place at the meeting.

The inquest heard evidence from Mr Greg Howden. He had lengthy dealings with Mr O'Connor and his family over many years. I was satisfied that, of all the persons at AGCC, he had the best understanding of Mr O'Connor. Mr Howden confirmed that he spoke with Mr O'Connor on the afternoon of 21 January 2013. He described a detailed face-to-face conversation with Mr O'Connor in the reception area of the MSU, as opposed to through the hatch of his cell. After this conversation Mr Howden was concerned enough to send an email to his colleagues which he produced to the inquest. The purpose of that email was to request that Mr O'Connor be assessed by a psychiatrist as a matter of urgency.

Mr Howden gave evidence that he was aware that a referral to PMHS had been made that afternoon, and that an appointment was booked for Mr O'Connor to see his usual treating psychiatrist, Dr Russ Scott, on 24 January 2013. Mr Howden also produced an email showing that he forwarded this information to the Deputy Commissioner of Queensland Corrective Services at the relevant time, Mark Rallings, on an 'FYI' basis.

Events of 22 January 2013

Ms Walton went to Mr O'Connor's cell on the morning of 22 January 2013. Ms Walton gave evidence that while he did not engage in a lengthy discussion, he responded to her questions. As a result of that conversation, Ms Walton did not believe that a crisis existed with respect to Mr O'Connor's mental health.

Although he had been assessed as being at a high risk of self-harm, at the inquest, Ms Walton, Ms Carr and Nurse Botha all agreed that they believed the risk could be appropriately mitigated by Mr O'Connor being observed every 30 minutes. They expected those observations would occur consistent with the instructions given, which required both physical and visual observations.

The MSU had lock down training scheduled for the afternoon commencing at around 1:00pm. Mr Mareales was the supervisor in the MSU at that time, and Mr Lumsden was the correctional officer in the control room. Contrary to AGCC policy, there were only two officers left in charge of the MSU.

Mr Mareales gave evidence that he was told about Mr O'Connor's exercise yard camera being covered at about noon. His response to that information was that it would need to be taken down after training, several hours later.

Mr Mareales also gave evidence that he did not seek replacement staff for those he had lost to the training session, leaving the MSU with two CCOs. The evidence at the inquest was that if a cell needed to be entered in the MSU, a minimum of three officers were required. If there had been an emergency situation with only two staff, a cell could not be entered.

The layout of the control room, arrangements with respect to the observation of prisoners, and how the CCTV in the cells and surrounds was set up were also canvassed at the inquest. Mr O'Connor's cell camera fed through to a dedicated screen. There was an additional screen monitoring movements of staff, and there was also a further screen which showed all other camera angles in the MSU on a recurring loop. Each camera angle would appear on screen for about 3 seconds, before shifting to the next view.

Mr Lumsden was in the control room operating the screens at the time of Mr O'Connor's death. His evidence was that he did not see that the exercise yard camera had been covered on the loop screen. The evidence provided was that if a camera was covered (which was a regular occurrence) it would appear on the loop screen as a blank or dark spot.

I am satisfied that if a correctional officer was diligently looking at the screens as required, it would be readily apparent that a camera had been obscured. Either Mr Lumsden failed to look at the screens on rotation or he saw the covered camera and, like Mr Mareales, simply did nothing about it.

It was just after 3:30pm when Mr Lumsden made an unsuccessful attempt to contact Mr O'Connor via his cell intercom. Mr O'Connor could not be seen from the cell camera, leading staff to the belief that he was in the exercise yard.

A code yellow and code blue were called. Entry was gained to the cell with the assistance of a corrective services dog. Upon entering the cell correctional officers were unable to see Mr O'Connor, so they continued into the exercise yard where they observed him hanging from the roof. The roof was made from reinforced steel mesh, inexplicably placed below a much finer steel mesh which was installed after the original roof – see figure 1.

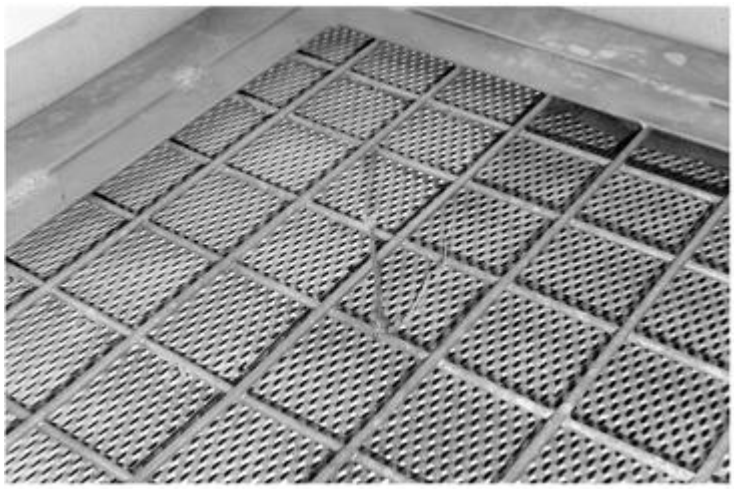

Figure 1- Exercise yard roof

Mr O'Connor was located at approximately 3:50pm. It appears that he had made the ligature out of a piece of green sheet which had been torn. It was thought to be the cover from the birdcage which Mr O'Connor kept in his cell, a cover which he had seemingly fashioned out of a bed sheet.

Mr O'Connor was cut down and QAS paramedics attended. However, he could not be resuscitated and was pronounced deceased at the scene.

Autopsy results

An external autopsy examination with associated CT scan and toxicology testing was carried out on 24 January 2013 by experienced senior forensic pathologist, Dr Beng Ong. Dr Ong's findings were peer reviewed by consultant forensic pathologist, Dr Alex Olumbe.

The examination showed a ligature mark around the neck, the origin of which was consistent with hanging. The pattern on the mark was in keeping with the accompanying noose being made out of linen. No injuries indicating possible third party involvement were observed.

The CT scan was unremarkable and showed no apparent fractures of the neck structures. There was a fracture of the left third rib which Dr Ong considered likely to be due to resuscitation efforts.

Toxicology results showed insignificant levels of diazepam and its metabolite nordiazepam. Tramadol was also detected. No alcohol or other drugs were detected.

Dr Ong concluded that the formal cause of death was consistent with hanging.

Adequacy of the mental health treatment and referral to the Prison Mental Health Service

The inquest investigated the adequacy of the mental health treatment provided to Mr O'Connor in the lead up to his death, and whether a referral to the PMHS should have been made earlier.

Dr Andrew Aboud, Clinical Director of the PMHS provided two statements and gave evidence at the inquest. Dr Aboud provided a history of Mr O'Connor's mental health, namely that he had been given a number of psychiatric diagnoses over the period of time he was being treated by the PMHS (2000 to 2012). His diagnoses were anti-social personality disorder, poly-substance use and a below average IQ. Psychiatric conditions which were queried over the years, but never confirmed, were low grade schizophrenia, schizo-affective disorder and bipolar disorder. As noted above, Dr Aboud had personally reviewed Mr O'Connor in early 2012.

Dr Michael Beech is a psychiatrist with many years' experience in Queensland who holds speciality qualifications in forensic psychiatry. His experience includes the assessment of prisoners for the Mental Health Court. Dr Beech provided an expert report to the inquest and also gave oral evidence.

Dr Beech's opinion was that Mr O'Connor should have been referred to the PMHS as early as Friday 18 January 2013. He also considered that the decisions made at the RAT meeting on 21 January 2013 were inadequate.

Dr Beech considered that Mr O'Connor was displaying clear symptoms of a psychotic episode in the days leading up to his death and his condition required exploration (and perhaps exclusion) by a psychiatrist. These symptoms included both visual and auditory hallucinations. His evidence was that the onset of psychosis would have nullified the protective factors that had been identified by Ms Walton, leading to a very high risk of suicide.

Dr Beech considered that continuous observations should have been initiated until Mr O'Connor had been assessed by a psychiatrist. He noted that in a community setting this would entail placement in a "bare room" without access to potential instruments of self-harm.

However, Dr Beech also accepted evidence provided by Dr Aboud about the referral process to the PMHS. Dr Beech accepted the evidence regarding the considerable logistical difficulties associated with moving a prisoner with Mr O'Connor's profile from a prison to a mental health facility.

Dr Beech's opinion highlighted various deficiencies in the RAT process at this time, including:

- potential hanging points in Mr O'Connor's cell were not brought to the attention of the RAT team;

- the general suitability of, and items contained within Mr O'Connor's cell not being discussed at the RAT meeting.

Dr Beech agreed that leading up to 18 January 2013, the mental health treatment provided to Mr O'Connor had been adequate.

I accept Dr Beech's evidence that Mr O'Connor's presentation from 18-21 January did require further exploration by a psychiatrist. An appointment with psychiatrist Dr Russ Scott, a psychiatrist known to Mr O'Connor, had been arranged for 24 January 2013 bypassing usual triage requirements. On the evidence heard at the inquest I consider that the timing of this appointment was made with a sufficient degree of urgency.

I also accept that Dr Beech had the benefit of hindsight in providing his opinion. He had the benefit of reviewing the entirety of Mr O'Connor's prison mental health records, his QCS records, all of the investigation material, and previous psychiatric opinions relating to Mr O'Connor. The relevant prison staff at the time did not have the benefit of all this material, or Dr Beech's level of expertise.

Dr Aboud agreed that Mr O'Connor's referral was significant and was given priority by the PMHS. However, he said that the fact that Mr O'Connor had been assessed as having a high risk of self-harm did not equate to him being mentally ill. He was unable to conclude that Mr O'Connor was psychotic at the time of his death and considered the observations regime implemented by the RAT meeting to be reasonable.

I accept Dr Aboud's evidence that ultimately it did not matter whether the referral to the PMHS was made on Friday, 18 January 2013 or Monday 21 January 2013. For logistical reasons, it is highly likely that Mr O'Connor would have still been in the MSU in his cell on the afternoon of his death.

Other options to accommodate Mr O'Connor while his mental health needs were being assessed were explored at the inquest. These included a transfer to the Woodford Correctional Centre or to a designated mental health facility. An observation cell in the Health Services Centre at AGCC was also considered but lacked shower and toilet facilities.

I accept Dr Aboud's evidence that entry to a high security mental health facility such as The Park depended not only on Mr O'Connor meeting the requirements for treatment under the *Mental Health Act 2000* but also on the availability of beds. It would have involved logistical considerations and extensive pre-planning for a prisoner like Mr O'Connor. At the time of his death there were no alternative beds available at The Park that would have safely accommodated Mr O'Connor.

The evidence at the inquest was that because Mr O'Connor was considered to be a violent and dangerous prisoner, the MSU should have been the safest place to hold him while his mental health needs were being explored. Dr Aboud explained that that this was because of the level of supervision

afforded by constant visual (CCTV) and physical observations, and daily reviews by prison psychologists. In Dr Aboud's opinion, the MSU was the most closely monitored, secure and risk averse environment in Queensland. Sadly, as Mr O'Connor's death has demonstrated, that was not the case.

Adequacy of the observation regime

The type and frequency of observations to be conducted on Mr O'Connor was made clear in the instruction sheet completed by Correctional Supervisor Roy Slade following the RAT meeting on the afternoon of 21 January 2013.

CCO Lumsden's evidence was that he knew that 30 minute observations were required. His evidence was that although the instruction sheet circled both physical and visual observations as being required, he thought visual CCTV observations alone were adequate.

CCO Lumsden was taken to the training induction he received when he first started at the MSU. This disclosed that he been trained to conduct observations in both a physical and visual manner. Despite that training and the clear instructions provided by Mr Slade, Mr Lumsden still considered there was a choice with respect to whether physical or visual observations were conducted.

The CCTV footage confirmed that Mr O'Connor's exercise yard camera had been covered by a piece of paper placed by Mr O'Connor on the morning of Monday 21 January 2013. It remained covered until he was found deceased on the afternoon of 22 January 2013.

I heard no evidence to explain why the exercise yard camera remained covered for such a long period. The monitoring screen would have been blank whenever it rotated to the exercise yard and this should have prompted an immediate response.

The CCTV camera footage from 22 January 2013 confirmed that Mr O'Connor could last be viewed on his cell camera at 2:19pm when he was seen to leave the view of that camera as he entered the exercise yard. He was not seen again after that time. Despite this, Mr Lumsden recorded that he was observed at 2:30pm, 3:00pm and 3:30pm. Contact was attempted via intercom just after 3:30pm. It was only then identified that something was wrong.

Mr Lumsden's evidence at the inquest with respect to this issue was provided under privilege. He gave evidence that the three logged observation entries between 2:30pm – 3:30pm were in fact made by him retrospectively after the incident. He was told to complete the form but Mr Lumsden could not recall who gave that direction. This appears to have been a hurried attempt to ensure the paperwork was in order before police investigators arrived.

Conclusions

Mr O'Connor died by suicidal hanging. Mr O'Connor's death may have been prevented if he had been observed in his cell in accordance with the Prisoner At Risk Instruction Sheet which required that he be observed both physically and visually (CCTV) every 30 minutes. That this was not done was a dereliction of duty on the part of the rostered custodial officers.

There was clearly a culture of complacency in the MSU at this time, not only with respect to the way in which observations of prisoners were conducted but also the treatment of covered CCTV cameras in cells.

I am unable to conclude that Mr O'Connor's death might have been prevented if his request to see a psychiatrist had been expedited. There were significant limitations involved in the movement of a prisoner with Mr O'Connor's profile to a secure mental health facility. Various levels of approval were required for this to occur ranging from the AGCC to the Deputy Commissioner, and Commissioner of Corrective Services.

I am satisfied from the evidence of Mr Howden, who appeared to have the best understanding of Mr O'Connor, that his condition on the afternoon of 21 January 2015 did not require that Mr Howden insist that he be moved to a secure mental health facility immediately - Mr Howden did not have the power to do so. Mr O'Connor's presentation was of sufficient concern to prompt Mr Howden to request urgent psychiatric review and he did so appropriately. Similarly, Mr Howden had limited options within the AGCC to safely place Mr O'Connor.

With respect to the effectiveness of the RAT meeting on 21 January 2013, I am satisfied that this was diminished by the fact that the authors of the relevant reports were not present to speak to their reports.

Of particular concern, correctional staff made no contribution to the RAT meeting. Information about the structure of the cell Mr O'Connor was being accommodated in, potential hanging points and items he had in his possession that might be used as ligatures was highly relevant to the assessment of risk of self-harm and the subsequent frequency of observations. Ms Walton and Nurse Botha were clearly not aware of these matters.

This ultimately led to a deficient RAT process. If the RAT meeting had been fully apprised it may have decided that more frequent observations were justified, that suicide resistant sheets and clothing should have been provided to Mr O'Connor and his cell stripped of potential ligatures.

I agree with the evidence of Dr Aboud that the MSU should have been a safe place for Mr O'Connor's mental health needs to be assessed. However, this was contingent on him being appropriately observed. His safety in the MSU also required that access to hanging points and other items also be restricted.

The response by Mr Mareales to the information that Mr O'Connor's exercise yard camera was covered was unacceptable. The fact that Mr Mareales did not seek to attempt to replace the staff who had left the MSU to attend training on the afternoon of the death, leaving only himself and Mr Lumsden in control of the MSU, was also unacceptable.

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 of the deceased – The deceased person was Scott Matthew O'Connor

How he died - Mr O'Connor died as a result of hanging in the exercise yard attached to his cell while he was an inmate in the Maximum Security Unit of the Arthur Gorrie Correctional Centre. He hanged himself by fashioning a ligature from a piece of sheet which he kept in his cell for use as a birdcage cover. He tied the ligature to the mesh roof of the exercise yard. At the time he hanged himself, the CCTV camera in the exercise yard was covered and had been covered since the previous day. Although Mr O'Connor had been assessed as being at high risk of self-harm he was not observed as required by the Risk Assessment Team.

Place of death – He died at Wacol in Queensland.

Date of death – He died on 22 January 2013.

Cause of death – Mr O'Connor died from hanging.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, 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 inquest investigated the adequacy of the response by AGCC to the recommendations made as a result of the investigations conducted by the QPS, the GEO Group and the OCI. At the inquest I heard evidence from the current General Manager of AGCC, Troy Ittensohn, regarding a number of

measures that have been implemented at the prison since Mr O'Connor's death. I also had regard to tendered written material from Mr Ittensohn.

While most of the recommendations contained in the OCI Report were directed to AGCC, some related to QCS and at the inquest I had regard to tendered written material from QCS.

It was confirmed in evidence at the inquest that the MSU is not operational and has not been since February 2013. There are currently no plans for it to be re-opened.

Of the recommendations made in the OCI Report, I am satisfied that those not implemented at this time are:

- Installation of infra-red cameras;
- That persons observing prisoners should be persons who have prior knowledge of the prisoner; and
- That RAT meetings be recorded.

At the inquest I was informed that AGCC would reconsider the decision not to implement the recommendation to record RAT meetings. I am satisfied that this recommendation is being reconsidered, and I appreciate the logistical matters that need to be taken into account in this process.

I accept that here are valid reasons not to implement the recommendations requiring the installation of infra-red cameras and persons observing prisoners to have prior knowledge of the prisoner.

A number of the recommendations related to the MSU, including the installation of covert microphones and CCTV in the control room, are all part of an action plan in the event that the MSU does become operational again. It was confirmed at the inquest that covert microphones and CCTV cameras are being installed in all control rooms in Queensland prisons including AGCC, and that before consideration is given to reopening the MSU microphones and CCTV cameras will be installed in the control room.

With respect to preventing a situation such as that seen with Mr O'Connor from occurring again, the recommendations of direct relevance are:

- An audit of all hanging points has been conducted by AGCC with the outcome being the implementation of an 'At-Risk Management Guide' which was issued in June 2014. The Guide shows all cell types at the prison and includes common areas. It lists the risks arising from the infrastructure and hanging points;
- The General Manager Directive issued in December 2013, which requires that all RAT members who are not custodial staff must have inspected each type of cell prior to commencing on the RAT.

With respect to the management of at-risk prisoners, the material provided by QCS confirms that suicide prevention training is provided to all employees at all prisons across Queensland. In addition to that, mental health staff at

AGCC have implemented the 'At Risk Management Training Manual' which lists a number of requirements with respect to:

- how handovers are to be conducted;
- what information is to be included in the At-Risk Management Plan (of particular importance, information about accommodation);
- the use of suicide resistant bedding and clothing; and
- the types of observations to be conducted and the level of detail required to be included in the observations log.

This inquest demonstrates that every effort must be made to ensure that prisoners who are identified as being at risk of self-harm are not accommodated in cells where they have ready access to hanging points or the means to fashion a ligature. The QCS procedure - At-Risk Management (Self Harm/Suicide) already provides:

> *Prisoners with an elevated baseline risk must be accommodated in a modern suicide resistant cell (i.e. a cell with reduced hanging points). In extenuating situations where reasonable factors warrant against allocating a prisoner identified as EBLR to a modern cell, the justification for the individual decision must be recorded in a case note on IOMS by a correctional supervisor after consultation with a correctional manager or the duty manager.*

Of the 616 suicides that occurred in Australian prisons between 1980 and 2013, 88 percent (545) were hangings.[2] While hanging deaths have declined since 2004–05, since 1979–80, 28 percent of hanging points (n=153) were a cell fitting and 25 percent (n=136) of hanging points were the cell bars. The most commonly used material in hanging deaths has been sheets (44 percent).

The inquest heard that it is not possible to place all prisoners assessed as being at risk of self-harm at the AGCC in cells without hanging points given their prevalence within the prison and the large number of prisoners assessed as being at risk of self-harm. Neither is it feasible for all such prisoners to be placed on continuous observations. This means that even greater reliance must be placed on the clinical judgement of those involved in the RAT process in making accommodation and risk management decisions with regard to the assessed risk to each prisoner.

The prison infrastructure at AGCC is the responsibility of the Queensland Government. It is of concern that prisoners such as Mr O'Connor are not able to be placed in a cell or other suitable accommodation without hanging points, even on a short-term basis until a more thorough assessment of their mental health status can occur. As Mr O'Connor's family submitted, the fact that he was labelled as a difficult or hard to manage prisoner should not have affected the way that he was treated. It is an accepted principle that prisoners should

[2] Australian Institute of Criminology, Deaths in custody in Australia: National Deaths in Custody Program 2011–12 and 2012–13

receive health care equivalent to that available in the community, without discrimination based on their legal situation.

I am satisfied that the recommendations already made, and the actions taken with respect to them, would make a significant contribution towards preventing a death in similar circumstances to Mr O'Connor from happening again. I adopt those recommendations. The recommendations made as part of the OCI Report are reproduced below (*numbered as per that report*).

> ***Recommendation 1*** *That AGCC must ensure and the Agency remind all centres to ensure that each RAT team must, as part of its decision making, determine the adequacy of cell infrastructure, specific risks presented by proposed accommodation, and make recommendations about the suitability of any current or proposed cell accommodation for at-risk prisoners and, where appropriate or necessary, make recommendations for the Centre to appropriately mitigate against any inherent risks present in the cell infrastructure which are unable to be avoided.*
>
> ***Recommendation 2*** *That AGCC management carry out an audit of hanging points, and ensure that officers involved in RAT meetings (including both operational and health professionals) are aware of those risks so that strategies may be put in place to mitigate against those risks.*
>
> ***Recommendation 3*** *That the Agency install covert microphones in the AGCC master control, and in the AGCC MSU master control, if and when it is reopened.*
>
> ***Recommendation 4*** *That the Agency install CCTV in the AGCC MSU master control room, if and when it is re-opened.*
>
> ***Recommendation 5*** *That the Agency conduct a review such that officers especially rostered to undertake observations should be persons who are familiar with the prisoner the subject of the observation regime or, if that is not possible, a person who is extremely au fait with at-risk indicators.*
>
> ***Recommendation 6*** *That the Agency conduct a review such that the psychologist who undertakes an assessment of an at-risk prisoner ought to be present at the RAT meeting, unless the psychologist attending is also familiar and current with the prisoner under consideration.*
>
> ***Recommendation 7*** *That AGCC must ensure that RAT meeting members ought not make determinations without the actual observations logs for a prisoner presently under a regime of observations and under consideration. "Chinese whispers" style summaries of observation logs are apt to be insufficient to allow RAT meetings to make fully informed decisions.*
>
> ***Recommendation 8*** *That the Agency conduct a review such that supervisors from the at-risk prisoner's accommodation area are involved in the RAT meeting and, in addition, that these supervisors are sufficiently addressing the issue of environment risks for each at-risk prisoner discussed at the relevant RAT meeting.*
>
> ***Recommendation 9*** *That AGCC review its rostering to identify officers who have spent extended periods of time exclusively on night-shifts and exclusively in master control positions, and act to ensure that those officers are provided with varied rosters to ensure broader ongoing centre experience, for the safety of those officers and prisoners.*
>
> ***Recommendation 10*** *That consideration be given for disciplinary action in respect of:*
> *(a) CCO Lumsden for:*

i. either deliberately or recklessly certifying in the observations log that he had undertaken observations when he could not possibly have done so; and
ii. informing Mr Ohlin that he had undertaken observations of Prisoner O'CONNOR when he could not possibly have done so.

(b) MSU Supervisors Mr Mareales and Mr Patterson for failing to ensure that the CCTV in the exercise yard of Prisoner O'CONNOR'S cell was uncovered.

Training

Recommendation 11 *That AGCC provide training on the management of at-risk prisoners to all relevant staff, including (without limitation):*

(a) Training to ensure that all officers in the Centre are current with their suicide prevention.

(b) Training to ensure officers understand the necessity for handover documents to contain comprehensive information. Those documents have much greater utility if the comments fields are populated with, even brief, relevant information, which could assist officers. Officers should be reminded of the purposes of these sheets and exemplar entries for the commentary section of those forms should be circulated to officers such that they may properly understand the kind of depth to which they are expected to condescend in completing these forms.

(c) Training to ensure that proper development of at-risk management plans by responsible officers. In this case there were no entries in the accommodation section.

(d) Training to ensure proper and vigilant implementation by officers required to comply with at-risk management plans. In this case, it directed a cell search for self harm objects, however the bird cage cover was allowed to remain and with that Prisoner O'CONNOR harmed himself.

(e) Training to ensure that all psychologists and mental health staff are aware of all relevant environment risks when conducting risk assessments.

(f) Training to ensure proper completion of the document titled "'Instruction - At Risk Prisoner" by relevant staff.

Recommendation 12*: That all relevant AGCC staff receive further training about at-risk indicators and how to identify them, and that AGCC implement stronger governance mechanisms for ensuring that all staff maintain current suicide prevention training and capability.*

Recommendation 13: *That training by AGCC should incorporate awareness of the importance of not being lulled into complacency by apparent improvements in the demeanour of an at-risk prisoner.*

Recommendation 14: *Training should incorporate awareness of the increased suicide risk to prisoners in isolation, seclusion or administrative segregation.*

Recommendation 15: *Training should incorporate information about environmental and operational factors that contribute to suicide.*

Recommendation 16*: That urgent training should be undertaken for all relevant staff (especially those engaged in RAT meetings and those otherwise required to make recommendations for at risk prisoners) regarding suicide resistant bedding and clothing, and the assessment of the circumstances in which suicide resistant bedding and clothing should be issued.*

Recommendation 17: *That further training (or refresher training) must be provided to all RAT members at AGCC so that each member is aware of:*

i.. all matters that must be properly assessed by the RAT meeting; and

ii.. whom, among the persons representing the various disciplines in attendance at the RAT meeting, is principally responsible for informing the other attendees about each matter to be assessed.

Recommendation 18*: That significant training (or refresher training) about how to conduct proper at-risk observations and how to case note those observations is required for all staff required to carry them out as part of their duties. This includes but is not limited to the following:*

(a) Training to ensure supervisors responsible for ratifying observations logs understand how to interpret observations instructions, how to ensure that officers for whom they are responsible are correctly adhering to instructions, and why it is not appropriate to ratify observations compliance in observations logs until after the observations have been carried out.

(b) Training to ensure that all officers in the Centre understand the purpose of at-risk observations instructions sheets; including, relevantly, how to complete them, why it is necessary to complete them in a consistent fashion using consistent language, how to interpret them, how to apply them, how and when to escalate concerns and issues, and why it is necessary to be familiar with them.

(c) Training to ensure observation officers understand what kind of information should be included in case notes and observation log commentary, including an understating that properly particularised information and statements of objective fact, rather than subjective assertions, are of greater assistance to those who have to rely on such information without the benefit of interviewing the at-risk prisoner in assessing and making recommendations for appropriate care regimes for at-risk prisoners.

Section 48

Section 48 of the *Coroners Act 2003* provides that a coroner must report offences if, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence. A coroner may also give information about corrupt conduct or police misconduct to the Crime and Corruption Commission.

I am satisfied that where there has been a failure or a departure from procedures on the part of an employee at AGCC this has been dealt with adequately through internal disciplinary processes undertaken by the GEO Group.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
14 August 2015