QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Russell Peter McBride**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2014/1097
DELIVERED ON:	5 August 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 July 2016; 3 August 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, suicide, welfare checks, hanging points, CCTV.

REPRESENTATION:

Counsel Assisting:	Mr P Johns
The GEO Group Australia:	Mr S Zillman (Instructed by Ashurst Lawyers)
Queensland Corrective Services:	Ms K Dixon

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Introduction

1. On the morning of 26 March 2014 Russell McBride failed to emerge from his cell at Arthur Gorrie Correctional Centre (AGCC) and was found to be hanging from a towel rack. A prison officer had conducted a welfare check on all prisoners in Mr McBride's unit less than 30 minutes earlier.

2. At 52 years of age, Mr McBride had spent just six weeks on remand at AGCC. It was his first period of imprisonment. He was not considered to have an elevated risk of suicide when assessed by prison staff and a psychiatrist. Mr McBride was subsequently accommodated in one of the many cells at AGCC with readily available hanging points consisting of exposed bars above cell doors for ventilation and fixed towel racks.

3. These findings:

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

   - consider whether any third party contributed to his death; and

   - consider the adequacy of the welfare check said to have been conducted on the deceased shortly prior to his being discovered hanging.

The investigation

4. An investigation into the circumstances leading to Mr McBride's death was conducted by Detective Senior Constable David Caruana from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

5. After notice of Mr McBride's death was received, CSIU officers attended AGCC and commenced an investigation. A search of Mr McBride's cell revealed two envelopes containing handwritten letters which were seized. Photographs were taken of the scene. The investigators obtained Mr McBride's correctional records and his medical files. McBride's fellow inmates at AGCC were questioned and statements taken from all relevant custodial and medical officers at AGCC. CCTV footage and relevant prison registers were obtained by police. These statements, interviews and other items were tendered at the inquest.

6. Dr Nathan Milne, an experienced forensic pathologist, attended AGCC to view the body of Mr McBride in situ. Dr Milne conducted a full autopsy examination of the body on 28 March 2014 and further photographs were taken at this time.

7. A separate investigation was conducted at the direction of the Queensland Corrective Services (QCS) Chief Inspector. A copy of the report into that

investigation was provided to my office and tendered at the inquest.[1] I found the investigation conducted on behalf of the Chief Inspector to have been thorough and the recommendations made valuable.

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

The Inquest

9. An inquest was held in Brisbane on 3 August 2016. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. I accepted the submission from counsel assisting, Mr Johns, that all evidence be tendered and that oral evidence be heard from only one witness, the QPS investigating officer.

10. I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

11. Mr McBride was born in Harare, Zimbabwe (then Rhodesia) on 28 July 1961. At the age of three his family emigrated, and Mr McBride spent the next 40 years living in Australia and New Zealand. In 2003 he moved to Australia with his partner and their one year old twin children.

12. Mr McBride worked in various positions while residing in Booval. These included delivering papers for a local newsagent and training greyhounds. He had no criminal history in Australia and no history of incarceration anywhere. However, on 9 February 2014, he was arrested and the following day, remanded in custody, on charges of stealing and stalking. These charges related to a series of alleged incidents involving a neighbour.

13. On 20 February 2014 Mr McBride was charged with two counts of rape. The complainant had travelled from New Zealand and stayed with Mr McBride and his partner in Brisbane during 2008 and 2009 and she told police this is when the offences occurred.

14. Mr McBride had been informed that further stalking charges were likely based on further complaints received by police. At the time of his death he had been due to appear in court for a further procedural hearing on 9 April 2014.

15. The charges led to Mr McBride's partner cutting off all contact with him, and between him and his children.

[11] Exhibit C20

16. Mr McBride is survived by his immediate family, two adult step-children (with whom he had no contact for many years) and by his brother, who has acted as next of kin for the purpose of the coronial process.

Assessment of mental health

17. There is no evidence that Mr McBride had sought mental health treatment before being imprisoned. On the evening of his arrest, 9 February 2014, Mr McBride was asked a series of standard questions at the Ipswich District watch house. He denied having ever been treated for a mental health problem (more specifically, for depression). He denied having ever attempted suicide or self-harm, or having thought of these things within the previous three months.

18. On 10 February 2014 Mr McBride was interviewed by the Queensland Health Forensic Mental Health Service, shortly before his court appearance. He denied "*suicide homicide or self-harm plan intent or ideation*" and was oriented and co-operative with the interviewer. It seems that, despite having no history of mental health problems, the interviewer remained concerned due to the nature of the stalking offence with which Mr McBride had been charged. A treatment plan was set as follows:

> *Await court outcome*
> *Advised to attend GP for mental health care plan and possible psychologist referral if released from custody*
> *Refer to PMHS if remanded in custody*

19. Mr McBride was transferred to AGCC on 17 February 2014 and later that day underwent a health assessment and an '*immediate risk needs*" (IRN) assessment. He told the assessing nurse that he had never suffered from any "*emotional or psychiatric problem*" nor had he ever thought about or tried to commit suicide. Mr McBride did describe himself as "*a bit down*", and "*a bit sad and anxious*" in relation to the status of his relationship.

20. The IRN assessment form completed by a counsellor on 17 February 2014 states:

> *Prisoner denied suicide/deliberate self-harm ideation recently or currently, and there was no available information to the contrary. Prisoner presented as future oriented, expressing desire to reunite with his partner and care for his children post release. Prisoner reported adequate external network, citing his partner as his main support. Prisoner reported that he does expect to receive visits while incarcerated, however, reported that he would cope sufficiently without visits. Prisoner reports that he expects to be incarcerated for two weeks, however, reports he would cope sufficiently should he be incarcerated for any significant period of time. Prisoner presented as calm, stable and accepting of current situation. Minimal current risk identified.*

21. The treatment plan recommended by the Forensic Mental Health Service had resulted in a referral to the Prison Mental Health Service (*PMHS*) when

Mr McBride was remanded in custody. He was seen by a psychologist from that service on 25 February 2014. Mr McBride was again noted to have no history of mental health conditions. He was observed to be irritable and presented with some paranoid and persecutory thoughts. Mr McBride again denied any "*thoughts/plans/intents to harm self or others*". The assessment states he was open to a further assessment by a psychiatrist and this was arranged for 4 March 2014.

22. Mr McBride was seen by psychiatrist Dr Zara Samaraweera on 4 March 2014. Mr McBride was evidently anxious about the lack of contact from his partner and his present circumstances but, according to the doctor, appeared to show good insight, affect and judgement. Dr Samaraweera wrote the following day to general health services at AGCC saying of Mr McBride:

> *He does not present with any evidence of psychotic or affective disorder and appears to be presenting with an adjustment disorder….I have not commenced Mr McBride on any pharmacological therapy and he agreed to self-refer to PMHS if he had further concerns*.

23. Lengthy handwritten notes found in Mr McBride's cell following his death show that over the following weeks he became increasingly distressed at the lack of contact from his former partner and children. While his writings clearly show an intention to end his own life, there is no evidence that he shared the extent of his distress with staff at AGCC or sought referral to any agency.

Events leading to death

24. The assessments carried out on Mr McBride led to his placement in a unit at AGCC made up of "old style" cells; namely Unit B1. The most significant difference between old and new cells at AGCC, for the purpose of this investigation, was that the old cells contained (and continue to contain) potential hanging points.

25. Newer cells are properly allocated to those prisoners deemed most at risk of self-harm. It is evident from this investigation and many previous coronial investigations that there are no short term plans to de-commission or modify the older cells at AGCC to remove potential hanging points.

26. QCS is responsible for providing fixed cameras and other infrastructure at AGCC The Queensland Government's position with respect to this issue, as set out in paragraph 70 of these findings, acknowledges that there are a number of secure cells in operation that do not have safer cell specifications.

27. On 25 March 2014 Mr McBride confided in a fellow prisoner that he had received a "return to sender" envelope that had initially been intended for his partner. The other prisoner described Mr McBride as appearing

"*depressed*" and had offered to buy Mr McBride a sketch pad as he knew Mr McBride liked to draw. This is the extent of the evidence from staff or other prisoners relating to Mr McBride's disposition on that day.

28. The prisoners in Unit B1 were locked in their cells at 6:00pm on 25 March 2014 as per standard practice. Policy in place at the time required a minimum of four headcounts prior to 7:00am the following morning. The policy states that at each headcount the prison officer is to satisfy themselves that each prisoner is in "apparent good health". The definition of an 'apparent good health check' undertaken on night shift in the QCS "Prisoner Musters and Head Count" Procedure states:

> ***'apparent good health'*** *Queensland Corrective Services has a duty of care to prisoners in QCS custody. This involves undertaking reasonable observations and/or engagement with the prisoner to ensure the care and well-being of prisoners. Apparent good health checks of prisoners is a dynamic and ongoing observation process, which is heightened during the conduct of headcounts/masters, unlock/lock away and unit patrols.*
>
> *Apparent good health of a prisoner must be determined by one or more of the following –*
>
> *During a day shift*
>
> *a. observing the prisoner to be in good spirit;*
> *b. observing the prisoner moving around freely;*
> *c. conversing with the prisoner;*
> *d. questioning the prisoner as to his/her care and well-being; and*
> *e. if appropriate, waking the prisoner to ascertain his/her care and well-being.*
>
> *During a night shift*
>
> *Officers must be vigilant for any unusual behaviours or occurrences that should be reported to the officer in charge. This will be based on good sense and sound judgement, noting that during a night shift the limited activity of a prisoner makes it difficult for an officer to determine the apparent good health of a prisoner.*

29. According to the relevant log for Unit B1, headcounts were conducted at 8:40pm, 10:27pm and 11:31 pm on 25 March 2014 and then at 1:57am, 4:33am and 6:56am the following morning. The last of these headcounts differed, in that it was conducted by two officers assigned to the day shift who had commenced at 6:30am. Although undertaken by day shift staff it

was carried out as if it were a night shift head count. The log records all prisoners as being in apparent good health for each of these headcounts.

30. Corrective Services Officers Asiata and Fibbes were on duty when Mr McBride was found hanging in his cell. It is apparent from the evidence that CSOs Asiata and Fibbes took differing approaches in relation to a night head count.[2] CSO Asiata told investigators that the purpose of a welfare check is to check that prisoners are alert and are breathing. He said that he did welfare checks the same way during the night, and that it was his usual practice to wake prisoners when they were sleeping.

31. CSO Fibbes conducted the observation of cell 36, which housed Mr McBride, as part of the 6:56am headcount. She later told investigators that she did not recall seeing Mr McBride and, therefore, could not recall what he was doing when she conducted the headcount.[3] She was adamant that she would have sighted him but that there would have been "*nothing untoward*" about his presentation. She knew this because had she seen anything untoward she would not have "*rung the headcount through*" to movement control.

32. CSO Fibbes told investigators that she would not wake prisoners during the night. In contrast, a day headcount would require her to get a physical or verbal response from a prisoner. CSO Fibbes gave examples of "untoward" presentations as blood over the floor, something covering the window of the cell, a prisoner hanging or lying on the floor.

33. In his interview with police on the day of the death a fellow prisoner confirmed that he had seen CSO Fibbes conducting the 6:56am head count while he was sitting having coffee in his cell.[4] He said "*I seen Andrea come around…* (she) *had a quick look in, went and did her morning head count, and then went down the fish bowl as far as I know, buzzed up and said unlock in five minutes...".*

34. Although CSO Fibbes did not independently recall where Mr McBride was located in his cell at 6:56am, she was asked how she might assess a prisoner seen kneeling in the corner of the cell with his back to the cell door (the position in which Mr McBride was found). CSO Fibbes told investigators that she may not necessarily find such a position concerning because the prisoner "*could be cleaning the toilet*".

35. CSO Asiata had the duty at around 7:20am of unlocking, among others, cell 36. When he unlocked cell 36 CSO Asiata noticed that Mr McBride was not near the door ready to present himself as required. When he looked into the cell CSO Asiata says he saw Mr McBride in a kneeling position near the toilet with his back towards the door. He initially thought Mr McBride was cleaning or praying so directed the prisoner to present himself. When there was no movement he called Mr McBride's name and moved into the cell.

[2] Exhibit C20, paragraphs 46 and 52
[3] Exhibit B7
[4] Exhibit E2

At this time he saw Mr McBride was tied to the towel rack with cloth type material.[5]

36. CSO Asiata stepped out of the cell and signalled to CSO Fibbes that Mr McBride was hanging. CSO Fibbes immediately called a "*code blue*" medical emergency over her radio.

37. At this time CSO Asiata realised that the cloth around Mr McBride's neck was too tight to remove. He did not have possession of a cut down knife and ran to the officers station to retrieve one. On his return he found that two previously unlocked prisoners had entered Mr McBride's cell and were attempting to cut the ligature with a razor they had found. After removing the ligature the two prisoners assisted CSO Asiata with resuscitation attempts until the arrival, approximately a minute later, of CSO Curtis McNulty.

38. The two prisoners who had assisted in the attempts to resuscitate Mr McBride were appropriately separated shortly after the incident and interviewed by police.[6]

39. At 7:24am, approximately four minutes after the code blue had been called, the medical centre emergency response team arrived. An ambulance was called and the first of two Queensland Ambulance Service (QAS) vehicles arrived at 7:38am.

40. Mr McBride was describe by various witnesses as "*cold to touch*", "*stone cold*" or in similar terms. He was noted to have a clenched jaw which created difficulty for CSO Asiata in applying a face mask. Mr McBride was declared deceased by a QAS officer at 7:53am.

41. The cell and surrounding area was secured; a log of events commenced and the unit was placed in lockdown pending the arrival of police officers from the CSIU.

Autopsy results

42. A full internal autopsy examination was conducted by experienced forensic pathologist Dr Nathan Milne on 28 March 2014. He had the benefit of x-rays, a CT scan and toxicology results when compiling his report, which was tendered at the inquest.[7]

43. Dr Milne had attended AGCC shortly after Mr McBride's death and had considered the police summary of events when forming his opinion.

44. In his report Dr Milne concluded:

[5] Exhibit B1
[6] Exhibit E2 and E3
[7] Exhibit A5

In my opinion, the cause of death is hanging. The post-mortem findings are consistent with the available history and examination of the death scene. There are no findings on my examination to suggest the involvement of another person in his death.

Investigation findings

45. Two neighbouring prisoners told investigators appointed by the QCS Chief Inspector that they heard noises coming from Mr McBride's cell during the early hours of 26 March 2014.

46. One prisoner, four cells away, recalled hearing a "*strange snoring/gurgle*" at around 4:15am though he had not thought much of it at the time. Another prisoner housed directly beside Mr McBride says that he was woken at approximately 2:30am by sounds coming from Mr McBride's cell. He described what he heard as the muffled sound of a person talking, combined with choking sounds. He had thought Mr McBride was talking in his sleep and listened in but could not make out what was being said.

47. Dr Milne, although specifically asked by investigators, said he was not in a position to give an estimate of the time of death based on the state of Mr McBride's body.

48. DNA samples taken from Mr McBride's left wrist shortly after his death returned a positive match for the DNA of another person known to police. An examination of prison records showed that person had been housed in the same cell as Mr McBride at an earlier time, but was no longer incarcerated at AGCC at the time of Mr McBride's death.

49. There was otherwise no evidence found that Mr McBride's cell was accessed by any person between 6:00pm on 25 March 2014 and the time he was discovered deceased the following morning. The evidence from prisoners, CCTV, CSOs and the logs in Unit B1 provide positive evidence for the proposition that Mr McBride's cell door remained locked for this entire period.

50. No illicit substances were found to be present in the blood and urine samples taken at autopsy.

51. The ligature used by Mr McBride to hang himself was found to have been fashioned from a sock and a section of bedsheet.

52. Lengthy handwritten notes found in Mr McBride's cell recorded an intention by the writer to kill himself due to despair over his general circumstances and, in particular, the estrangement from his partner and children.

Conclusions

53. I am satisfied that no staff or prisoners at AGCC were involved in the death of Mr McBride.

54. I am satisfied that the efforts to revive Mr McBride when he was discovered hanging in his cell adhered to procedure and that the staff members and prisoners involved are deserving of praise for their efforts.

55. I accept that CSO Fibbes conducted a headcount at around 6:56am and that, as required, she checked on Mr McBride. However, it is unclear where Mr McBride was located in the cell at this time. I am unable to determine on the evidence before me exactly when Mr McBride hanged himself. It may have been before or after the 6:56am headcount.

56. Although his body was described as cold to touch by those who attempted CPR[8] I accept that Dr Milne was unable to estimate the time of death, and I am unable to draw any conclusions from the state of Mr McBride's body when he was located.

57. I also accept that the positioning of Mr McBride was unusual in the context of a prisoner who has hanged himself. The evidence of CSO Asiata that he had initially thought Mr McBride was praying or cleaning is supportive of the proposition that CSO Fibbes' failure to spot anything alarming was reasonable. On that basis, I do not consider any criticism of her is warranted.

58. CCTV footage showing CSO Fibbes conducting the headcount at the door of Mr McBride's cell would have assisted in the resolution of these issues. Unfortunately, the CCTV camera was positioned so that no such footage could be obtained.

59. I am satisfied that the procedures in place to identify whether Mr McBride was a risk of self-harm or suicide were adequate and that they were followed appropriately. The procedures worked to ensure that Mr McBride was referred to PMHS and received a prompt review by a psychiatrist, even though it might be said that this was a case of erring on the side of caution. I accept that there was no evidence available to any of the counsellors, nurses or other professionals who assessed Mr McBride to indicate that he was at unacceptable risk of self-harm.

Findings required by s. 45

60. 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 Russell Peter McBride

[8] In determining the appropriate weight to place on the apparent state of Mr McBride's body I note that indicia such as rigor mortis and body temperature can be affected by many internal and external factors and are unable, on their own, to be used to establish time of death with any great deal of precision.

How he died - Mr McBride intentionally hanged himself from a towel rail in his cell at Arthur Gorrie Correctional Centre while on remand for serious sexual offences.

Place of death – He died at the Arthur Gorrie Correctional Centre at Wacol in Queensland.

Date of death – He died on 26 March 2014.

Cause of death – Mr McBride died from hanging.

Comments and recommendations

61. Section 46 of the *Coroners Act*, 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.

62. At the time of Mr McBride's death there was a single CCTV camera covering the unit in which he was housed. The camera could be rotated to provide a view of the upper landing where Mr McBride's cell was located. However, it could not provide a view of what was occurring inside the cells. At the time CSO Fibbes conducted her 6:56am headcount the camera was facing away from Mr McBride's cell so there is no footage which could have immediately corroborated CSO Fibbes' account of having looked into Mr McBride's cell at this time.

63. At the inquest a statement was tendered from the General Manager of AGCC (and employee of GEO Australia), Mr Troy Ittensohn in response to recommendations contained in the Chief Inspector's Report.[9] In it he notes that QCS is responsible for providing fixed cameras and other infrastructure at AGCC. Mr Ittensohn supplied documentary evidence that a detailed capital works proposal has been put to QCS for a significant increase in the number of CCTV cameras fitted.

64. A statement from Mr Timothy Thomson,[10] a Project Manager with QCS, was tendered at the inquest. He confirmed that the capital works proposal has been approved. Scheduled capital works will see the installation of three CCTV cameras in Unit B1 which will have a fixed field of view covering 95% of the unit. However, Mr Thomson's statement indicates that cell corridors are not provisioned with cameras as corridors are a thoroughfare only for prisoner access or egress from their cells, and not for prisoner congregation.

65. Extra cameras will also be installed in a number of other units and exercise yards throughout AGCC. All extra cameras are scheduled to be fitted by

[9] Exhibit B19
[10] Exhibit B20

the end of 2016. The capacity for CCTV footage to simplify future court proceedings, saving time and cost, is obvious. Their installation has the capacity to protect both prisoners and corrective services officers when any allegations of mistreatment, misbehaviour or regulatory failure are made.

66. While it appears that the corridors in the accommodation wings of Unit B1 will not be fully visible from the upgraded CCTV cameras, it will be possible to see persons entering and leaving those passages.

67. As noted above, there was no evidence of a failure to conduct an adequate headcount in this case. However, the evidence has highlighted the need to ensure headcounts are being conducted diligently. In the absence of extra CCTV cameras, I accept that the best method to ensure compliance is through regular auditing of the process to ensure that CSOs are performing welfare checks satisfactorily, day and night.

68. I accept the evidence of Mr Ittensohn that corrective supervisors at AGCC are required, during day shift, to conduct random checks of the areas under their supervision on procedural matters including headcounts.[11] They are required to observe (in person or via CCTV) a muster, head count, unlock or lock away, and record details in an oversight control document. I am not inclined to make a recommendation about these checks as the GEO Group has already implemented a random audit process, and I have not found a failure in this instance that contributed to Mr McBride's death.

69. In response to a submission from counsel assisting at the inquest that consideration could be given to extending this supervisory requirement to headcounts conducted during the night shift, an undertaking was given to the court by the GEO Group that it would institute an audit process with respect to night welfare checks. As there are fewer supervisors on duty at night, the audit will be based on random checks with reference to CCTV cameras. I accept this undertaking and do not consider it necessary to recommend that this extra audit process be implemented.

70. Although it would have made no difference in the case of Mr McBride, I note the change in practice at AGCC requiring CSO's conducting the "*unlock*" of cells now carry a cut down knife.

71. On 8 October 2015 the Minister for Police, Fire and Emergency Services and Minister for Corrective Services provided the following advice in relation to the Queensland Government's response to previous coronial recommendations about the presence of hanging points at AGCC and other prisons:[12]

> *Since 1996, the Queensland Government has invested more than $1 billion in construction of new design safer cells and*

[11] Exhibit B19.3, Post Order, AGCC Accommodation, dated 22 March 2016.
[12] Queensland Government Response - Inquests into the deaths of Christopher Steven Bell, Robert Gary Mitchell and Adam Cartledge; http://www.courts.qld.gov.au/courts/coroners-court/findings

modification of older style cells. Infrastructure projects at Lotus Glen, Southern Queensland, Brisbane, Townsville and Arthur Gorrie Correctional Centres have contributed to the reduction of hanging points. Additionally, specific funding was provided to convert as built cells to safer cell design at the Arthur Gorrie Correctional Centre. Currently, 85% of secure cells have safer cell measures in place with 650 cells throughout the state yet to be modified; 138 cells at Townsville, 268 cells at Arthur Gorrie and 244 cells at Borallon Training and Correctional Centres.

…..

Queensland Corrective Services (QCS) has a duty of care to provide a safe environment for prisoners managed within QCS facilities and is committed to minimising self-harm and suicide. The department has developed and implemented a range of management strategies in relation to best practice principles to reduce self-harm and suicide in correctional centres. These strategies are largely incorporated in the Risk Management Practice Directive and related documents and are implemented at various points throughout a prisoner's contact with QCS. QCS has and continues to increase the number of safer cells in Queensland correctional facilities using a three phased approach.

First, QCS ensured that a limited number of 'safer' prisoner cells were established within each correctional centre. These were then available to house those prisoners individually identified as being at-risk of suicide/self-harm. Second, as capital funds become available, cells are modified either as a separate project or as part of a site-wide redevelopment project to safer cell specifications. Finally, all new cells constructed since 1996 are designed to minimise self-harm and safer cell designs have been refined since that time. Safer cells are available in secure cell accommodation at every correctional centre within the state. However there are a number of secure cells which remain in operation that do not have safer cells specifications in place.

72. I close the inquest.

Terry Ryan
State Coroner
Brisbane
5 August 2016