QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David John BUCKNALL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/915
DELIVERED ON:	7 August 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	15 June and 6 August 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody; suicide; psychiatric care of prisoners

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Kay Philipson
Queensland Health:	Mr Kevin Parrot

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The *Coroners Act 2003* provides in s47 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 David John Bucknall. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

David Bucknall was 41 years of age and had been incarcerated at Wolston Correctional Centre (WCC) for almost two years when he died there on Tuesday, 16 March 2010. During that period Mr Bucknall was treated by staff from the prison mental health service (PMHS).

After he failed to attend a course early on the afternoon of 16 March 2010 a corrections officer entered Mr Bucknall's cell and found him slumped on the inside of the door. Wrapped tightly around his neck was a cord from a prison laundry bag. Immediate and ongoing attempts to resuscitate Mr Bucknall were unsuccessful.

These findings:

- verify the identity of the deceased person, how he died and the time, place and medical cause of his death;
- determine whether any third party contributed to his death;
- evaluate whether corrections and medical staff charged with providing for the deceased's needs while he was in custody adequately discharged those responsibilities; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Detective Sergeant Myke Anderson of the QPS Corrective Services Investigation Unit (CSIU) conducted an investigation into the circumstances leading to the death of Mr Bucknall. He attended WCC in the hours after the body of Mr Bucknall was discovered and observed the body *in situ*. Detective Sergeant Anderson later compiled a report of his investigation which was forwarded to my office.

Accounts from corrections officers and nursing staff at WCC established that once resuscitation attempts ceased, Mr Bucknall's cell and, shortly after, the whole residential unit "Romeo 3 Delta" (which contained his cell), was closed and secured. Another detective from the CSIU and a police photographer arrived at WCC at 3:15pm, around an hour and a half after Mr Bucknall had

been declared deceased. Photographs were taken of the cell and of the body *in situ.* On his arrival, Detective Anderson conducted a careful examination of the cell looking for signs of violence or anything else inconsistent with the version of events given by prison staff.

QPS scientific officers attended WCC and conducted an examination of Mr Bucknall's cell and took swabs from several locations in case they were needed for later analysis. A finger print officer attended on 17 March 2010 and collected a number of samples.

The cord said to have been found around Mr Bucknall's neck was seized as were all custodial and medical records relating to him.

CSIU officers conducted interviews with all prisoners in Mr Bucknall's unit as well as three other surrounding units.

Detective Anderson obtained statements from two doctors who had attended to Mr Bucknall's physical and mental health in the lead up to his death. He also obtained statements from staff at the PMHS, including Mr Bucknall's treating psychiatrist.

An analysis of phone calls made by Mr Bucknall in the months prior to his death revealed important information and these tape recordings were seized and subsequently transcribed. Statements were obtained from friends and family members of the deceased in relation to his demeanour in the period leading to his death.

A separate investigation into the circumstances of the death was ordered by the Chief Inspector of Queensland Corrective Services (QCS). That investigation was conducted by a senior inspector, Mr Kerrith McDermott together with an independent investigator, Mr Rod Hayes. Those two people authored a detailed report into their findings and recommended a number of changes to QCS policy and procedure. A copy of the report was tendered as an exhibit at the inquest

I find that the QPS investigation into the death of Mr Bucknall was thorough and professionally conducted. I am satisfied that all relevant information was tendered at the inquest. I commend Detective Anderson and the Chief Inspector's investigators for their endeavours.

The Inquest

A pre-inquest conference was held in Brisbane on 15 June 2012. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the Department of Community Safety and the West Moreton Health Service District.

An inquest was held in Brisbane on 6 August 2012. All of the statements, records of interview, medical records, photographs and materials gathered

during the investigation were tendered at the inquest. Four witnesses, including the investigating officer, gave oral evidence.

The evidence

Personal circumstances and custodial history

David John Bucknall was the third of four children of his parents Graham and Carol Bucknall. He was born on 20 December 1968 at Brisbane.

He undertook brief service in the Australian Army before being discharged as medically unfit. He later held intermittent employment although was unemployed in the lead up to his incarceration in April 2009.

Mr Bucknall began a relationship with Karen Brook in May 1996 which continued until February 2008 (with ongoing contact thereafter). Together they had two children.

Mr Bucknall had no criminal history until 20 April 2009 at which time he was sentenced to 6 years imprisonment in the District Court at Ipswich for the offence of *Maintain an unlawful relationship with a child*. These offences took place between 30 December 1997 and January 2001.

Mr Bucknall was initially accommodated at Brisbane Correctional Centre and on 8 May 2009 transferred to WCC where he remained until his death.

Medical and psychiatric history and treatment at WCC

Mr Bucknall's mother suspects that he suffered from depression as early as his teenage years but certainly by his early 20s Mr Bucknall had been formally diagnosed as suffering from this condition and received treatment for it over many years.

In the early hours of 16 July 2008 Mr Bucknall was taken by ambulance to Ipswich Base Hospital emergency department where he presented as having ingested a large amount of antidepressant medication. He told doctors that he did so in order to help him sleep and denied suicidal intent. He was seen by the psychiatric registrar to whom he admitted having contemplated suicide in the past but again denied any current intent of suicide. This incident occurred at a point when Mr Bucknall was experiencing stressors including the recent separation from his partner and the prospect of being imprisoned.

Medical records from his usual general practitioner (GP) show that in February and March of 2009 he presented with bronchitis and he complained that he was depressed and not sleeping due to his knowledge, by then, that he would be going to jail soon. Dr Cecil Doughty, the GP, considered Mr Bucknall no more depressed than one might expect anyone else facing a jail term. He told investigators that Mr Bucknall did not appear suicidal.

After his sentencing, Mr Bucknall was asked a series of health related questions by police prior to his being lodged at Ipswich watchhouse. He told

police that he had never attempted suicide or self harm but that he had had thoughts of suicide or self harm in the past three months.

On arrival at Brisbane Correctional Centre (BCC) on 22 April 2009 Mr Bucknall underwent an initial risk and needs assessment (IRNA) in which he related the incident of July 2008 in which he had taken an overdose. He told the psychologist conducting the IRNA that this had been an accidental overdose and again stated that he had not previously attempted suicide or self harm. He disclosed his history of depression. This, combined with his disclosure of the accidental overdose resulted in a referral by the staff at BCC to the PMHS.

On 1 May 2009 Mr Bucknall was seen by a visiting medical officer who prescribed the antidepressant medication Avanza. That doctor also conducted an assessment of Mr Bucknall's chronic condition of emphysema.

When Mr Bucknall was transferred from BCC to WCC on 8 May 2009 the transfer form specifically noted his history of depression. A box marked "*Previous suicide attempts*" had been ticked with the added explanation beside it: "*Accidental OD (2008)"*. The information management system adopted in Queensland prisons enables a "flag" to be attached to a prisoner who has previously attempted self harm or suicide. Mr Bucknall was not flagged in this way at either BCC or at WCC.

The report prepared for the QCS Chief Inspector was critical of WCC for apparently having no system in place to assess whether or not an inmate has an elevated baseline risk of self harm or suicide. The basis of this finding was unsourced in their report.

The inquest heard from the current general manager of WCC, Ms Sharon McCallum-Clark. She also held that position at the time of Mr Bucknall's imprisonment. Ms McCallum-Clark explained the process of assessment for risk of suicide or self harm in place at WCC at the time Mr Bucknall was received. It has not changed substantially since. All prisoners arriving at WCC are seen by a member of the Operational Counselling and Psychological Services Team. This person is usually a psychologist. That member of staff seeks to identify whether a prisoner has an elevated baseline risk of self harm suicide. If so that prisoner is seen again one week later for further assessment. The management of such prisoners can include the use of regular visual observation for the implementation of a program to identify any deviations in behaviour so that they are identified over time.

On 8 May 2009 Mr Buckland was seen by a member of the Operational Counselling and Psychological Services Team, Rebecca Jackson. Ms Jackson recorded an entry on the computerised offender management system in which she recorded his history and diagnosis of depression, the accidental overdose of July 2008, details of his current medication and the problems relating to his relationship with Ms Brook. She recorded that Mr Bucknall denied any suicidal or self harm behaviours "*since the overdose."*

She also noted Mr Bucknall denied any current suicidal ideation, plan or intent. Ms Jackson concluded as follows:

> "*It is assessed at the offender presented as minimal risk of suicide or deliberate self harm."*

Ms Jackson told Mr Bucknall that a psychologist or councillor was available for him to speak to in the unit on a daily basis should he wish to discuss any personal issues.

It was apparently not clear to Mr Bucknall what arrangements, if any, had been made for him to see a psychiatrist, notwithstanding the request made by staff at BCC on 22 April 2009. So, on 19 June 2009 he submitted a Prisoner Request Form stating "*Request psychiatrist regarding my medication for depression*". This seems to have prompted some action and arrangements were made for a PMHS psychologist to see him. It is apparent from the evidence given at the inquest that the delay in this case between referral to PMHS and a forensic intake assessment was (and is) not unusual.

On 29 June 2009, Mr Bucknall was seen by Ms Corinne Clifton, a psychologist attached to PMHS, for an intake assessment. She recorded a history consistent with what Mr Bucknall had previously disclosed and formed the opinion that he should be referred for psychiatric assessment. Mr Bucknall first saw a psychiatrist from PMHS on 8 July 2009. This was the first of 16 psychiatric sessions during his period of incarceration. As a result of the first of these sessions Mr Bucknall was prescribed the psychotropic medications mirtazapine (60mg nocte) and, later, quetiapine (100mg mane; 200mg nocte).

The inquest heard from Dr Anthony Tie who was Mr Bucknall's treating psychiatrist from 8 July 2009 onwards. He said that on this first occasion and during all of the subsequent sessions that Mr Bucknall adamantly denied a history of deliberate self harm or suicidal thoughts. Dr Tie had noted on 8 September 2009 that Mr Bucknall was "*vulnerable to deterioration into major depressive episode given borderline and dependent traits"*. Dr Tie told the inquest that despite this vulnerability he did not observe Mr Bucknall deteriorate into such a state. The last time Dr Tie saw Mr Bucknall was on 25 January 2010. At that time he considered that Mr Bucknall had adjusted fully to his situation; that he was getting on well with others in the unit and that he was future orientated, planning, for instance, to quit smoking and get fit.

Previous psychiatric appointments had been set depending on need and had varied from 1 to 6 weeks. After the appointment of 25 January 2010 a further appointment was made for 16 March 2010, approximately 6 weeks away.

At some time on 16 March 2010 Mr Bucknall was called via intercom to attend a scheduled appointment with Dr Tie. Notes in his medical file indicate he "declined" to attend this appointment. Dr Tie told the inquest that he made this entry. He said he would not have spoken directly to Mr Bucknall but would have relied on information from corrective services staff in forming the view that Mr Bucknall had "declined" to attend. The reason Mr Bucknall failed to

attend his appointment or respond to calls over the intercom can not now be established.

Events leading to the death

On 27 October 2009 Mr Bucknall received a letter from Karen Brook which made it clear that she considered their relationship to be over. On 30 October 2009 Mr Bucknall made contact with the PMHS case coordinator based at WCC who organised for him to be seen the following week by Dr Tie. This consultation resulted in an increased dose of Quetiapine. Dr Tie stressed the need, as he said he always did, for Mr Bucknall to seek assistance from the PMHS case coordinator or other counsellors at the WCC should it be needed. Dr Tie renewed the psychiatric clearance already in place deeming Mr Bucknall unfit for work. Dr Tie told the inquest that he stressed during his consultations with patients that the custodial setting is unpredictable and that if things took a sudden turn for the worse he would do everything possible to be available at short notice.

The letter from Ms Brook did not bring an end to the ongoing contact between her and Mr Bucknall. They spoke regularly by phone and it seems that Mr Bucknall continued to hold out hope that the relationship might be reconciled. He told Ms Brook that he wanted her to "*look him in the eye*" when telling him the relationship was over. It seems it would only be then that he would accept it. This is exactly what happened on 13 March 2010 when Ms Brook visited the WCC.

The visit on 13 March 2010 appears to have had a significant effect on Mr Bucknall. Ms Brook considered that finally, he accepted there was no prospect of their relationship continuing. In the following days his pattern of calls to Ms Brook changed and the content of those calls can be seen, in hindsight, to reflect an expectation that he would soon be dead. Mr Bucknall stopped making his regular daily calls to his mother.

The other possibly significant event that occurred in early 2010 was the service upon Mr Bucknall of an application for criminal compensation from the victim of the offence for which he was imprisoned. The supporting documentation for the application would have made explicitly clear to Mr Bucknall the damage he had caused.

At about 11:00am on 16 March 2010, Mr Bucknall spoke to Charles Hayes, a fellow inmate. He told Mr Hayes that he had a headache and needed to lie down from while. Knowing that a laundry collection was imminent he asked Mr Hayes to hand over his laundry so that he would not be disturbed. He ended this conversation with "*Alright thanks. Thanks for being a good friend".* Mr Bucknall then entered his cell and commenced playing music, perhaps to conceal the sound of what he was about to do.

The discovery of Mr Bucknall's body

Shortly after 1:00pm, two programme facilitators from the "Getting Started" program for sex offenders attended residential movement control. They asked

that Mr Bucknall be paged over the intercom system because this was the second day in a row that he had failed to attend the course.

Messages sent in this way are audible to all prisoners in a particular unit but they are not audible to the CCO assigned to supervise the cluster if the door to the officer's station is closed.

At 1:10pm, after Mr Bucknall had failed to respond to a number of calls, another prisoner, Garry Hughes, made his way from the unit to the officer's station. On this day the supervising CCO for Romeo 3 Delta was Kafoa Osotonu, who gave oral evidence at the inquest. Mr Hughes told CCO Osotonu of the calls for Mr Bucknall and his apparent failure to respond. CCO Osotonu made his way to the unit where he noticed a single prisoner, Paul Streeton, sitting in the communal kitchen. Mr Streeton directed Mr Osotonu to Mr Bucknall's cell.

CCO Osotonu noticed that a towel was covering the inside of the window on the door to Mr Bucknall's cell and that the cell door was locked. Using his key he unlocked the door and immediately noticed that something on the other side was impeding his attempts to open it. Such was the effort required to open the door that he initially thought Mr Bucknall may have been actively trying to prevent it being opened in order to conceal some sort of improper activity. CCO Osotonu redoubled his attempt to open the door and in doing so noticed the body of Mr Bucknall fall from an apparent sitting position to the right. It seemed to CCO Osotonu that Mr Bucknall had been in a sitting position with his back to the inside of the door.

CCO Osotonu immediately took steps to remove a white cord he observed to be around Mr Bucknall's neck. He felt for a pulse and could not find one. Mr Bucknall was not breathing. CCO Osotonu called a "Code Blue" over the radio and commenced CPR.

Other correctional officers and two nurses quickly arrived on the scene and assisted with resuscitation attempts. A portable defibrillator indicated that there was no shockable cardiac rhythm, suggesting Mr Bucknall's heart had stopped some time ago. CPR continued for approximately 15 minutes before it was apparent to the nursing staff present that Mr Bucknall could not be revived. In the course of administering CPR Mr Bucknall had been moved from his cell in order to provide more room and better access to resuscitation equipment.

CPR was unsuccessful and Mr Bucknall was declared deceased by nursing staff at 1:31pm. QAS officers arrived at 1:34pm having been called at 1:19pm. They confirmed that his heart was pulse-less – in asystole.

Investigation results

Soon after Mr Bucknall was declared dead, the unit was secured and the investigation detailed earlier commenced.

Detective Sergeant Anderson did not locate any signs of trauma on the body of Mr Bucknall when he observed it *in situ* at WCC as part of his initial investigation. There were no signs of violence or theft. The detective told the inquest that his investigation revealed no evidence indicating a second person had been involved in causing the death of Mr Bucknall.

It was apparent the cord found around Mr Buckanll's neck had been taken from a standard issue laundry bag given to all prisoners. It appears Mr Bucknall had removed it from the bag and knotted the ends so that it could be wedged between the top of the cell door and the door jam when the door was closed.

It seems he put his head through the loop that was formed, crossed it over under his chin and looped it again over his head, before bending his legs and allowing the cord to bear his weight.

A note found in Mr Bucknall's cell said of his fellow inmates: "*… none of them are aware of the depth of my depression"*. It also said, *"I just can't live with myself for all of the pain and suffering I have caused my victim and family."*

Autopsy results

An internal autopsy examination was carried out on 17 March 2010 by an experienced forensic pathologist, Dr Kathryn Urankar. After considering toxicological and serological results Dr Urankar issued a report in which she stated:

> *"Autopsy examination of this middle-aged male demonstrated an abrasion mark around the neck consistent with that scene following suicidal hanging. The mark appeared to become all around the neck implying that a rope had been wrapped twice around the neck. One mark appeared to be roughly horizontal around the base of the neck and the second showed an upwards slant, running upwards on the neck from the right to the left side of the neck creating a suspension point on the left hand side of the head.*
>
> *No other marks were noted on the anterior neck to suggest a struggle or the participation of a second/third party in the death.*
>
> *Internal examination of the structures of the neck did not demonstrate any evidence of bruising in the muscles of the neck, however, there was fracture of the horns of the thyroid cartilage with associated haemorrhage in the adjacent soft tissue. This injury is commonly associated with hanging.*
>
> *Toxicology was performed on a sample of blood taken at the time of autopsy. This demonstrated the presence of the antidepressant mirtazapine in levels above the documented therapeutic range but well below known fatal levels. The antipsychotic medication quetiapine was detected in approximate therapeutic levels. Paracetamol was also*

detected in therapeutic levels. These drugs would not have contributed to death. No alcohol or other drugs were detected."

As a result of her findings, Dr Urankar issued a certificate listing the cause of death as:

1(a) Hanging

Conclusions

There is no evidence that anybody else was directly involved in Mr Bucknall's death. On the contrary, all of the evidence points to him intentionally taking his own life as a result of remorse for the impact of his crimes and despair at the loss of his relationship with his partner.

Mr Bucknall suffered from chronic depression that may have exacerbated the adjustment disorder experienced when he was in prison. He received appropriate medical treatment for his psychological conditions while in prison. There was no evidence that his condition had become acute in the days immediately prior to his death that those responsible for his welfare could have been reasonably expected to detect.

In particular, there is no basis on which to conclude that any inmate or member of staff at the WCC or any member of the PMHS ought to have been aware that Mr Bucknall was at heightened risk of suicide in the days before his death.

I am also satisfied that once discovered corrective services staff acted promptly and appropriately in attempting to revive Mr Bucknall. CSO Osotonu in particular is to be commended for his immediate and ongoing efforts to resuscitate Mr Bucknall.

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 in relation to the other aspects.

Identity of the deceased – The deceased person was David John Bucknall.

How he died - Mr Bucknall intentionally took his own life by hanging himself from a cell door with cord obtained from a prison laundry bag while he was in custody.

Place of death – He died at Wacol in Queensland.

Date of death – He died on 16 March 2010.

Cause of death – Mr Bucknall 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 circumstances of Mr Bucknall death give rise to three issues on which it is appropriate to comment further:

Adequacy of psychiatric care

On 22 April 2009 at the BCC and again on 8 May 2009 at the WCC Mr Bucknall was assessed as not having an elevated baseline risk for suicide or deliberate self harm. I am satisfied that in both cases this was a reasonable conclusion to draw. During the first of these assessments it became apparent that Mr Bucknall's psychiatric history warranted his referral to the PMHS. It took more than two months for Mr Bucknall to then be assessed by a staff member from that service.

There is no evidence to suggest that the length of time between referral and Mr Bucknall being seen was due to any individual failure; rather it is a timeframe arising from the limited resources available to the PMHS when measured against the enormous caseload it must manage. Such delays are at odds with the obligation of QCS to maintain equivalency between the quality of health care provided to prisoners and that provided to other members of the community. It remains to be seen whether the decentralising of prisoner health services will hinder or improve this aspect of health care.

Once Mr Bucknall was accepted by the PMHS it is clear that he received a good level of psychiatric care. Dr Tie impressed as a practitioner who gave a great deal of thought to the unique setting in which his patients found themselves and the way, therefore, that he interacted with them. I am satisfied that there is nothing further he could reasonably have done to alter the course of events for Mr Bucknall.

Design of laundry bags at WCC

The General Manager of WCC, Ms McCallum-Clark told the inquest that laundry bag cords were removed from use in the accommodation areas at the WCC immediately following Mr Bucknall's death. On her direction hats used at the facility with similar, albeit shorter, cords were also removed from use.

The inquest heard that the manner of Mr Bucknall's suicide was unique. Recognising this, a description of the method used has been disseminated among the General Managers of prisons throughout Queensland so that they might onside prevention strategies.

I am satisfied no further comment from me is necessary in relation to this issue.

Failure of prisoner to respond when called

Ms McCallum-Clark supplied documents to the inquest showing that following Mr Bucknall's death directions were given for staff at the WCC to be more vigilant in following up on prisoners who fail to respond to calls. I am satisfied that this addresses the recommendation made in the report to the Chief Inspector, QCS.

It would seem that the most obvious person to conduct such follow-up would be the CCO directly supervising the unit which houses the relevant prisoner. Yet, in some cases, this officer is not in a position to hear intercom calls to a prisoner.

I accept the submission of counsel for the Department of Community Safety that, in order to make a recommendation addressing this issue, it would be necessary to receive further evidence relating to the work practices of CCO's in such a position. I also accept that the direction issued by Ms McCallum-Clark can be easily followed by movement control officers using radio and telephone facilities which readily connect them with the supervising CCO.

In the circumstances I do not propose to make any further comment or recommendations.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
7 August 2012