OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Andrew James COCKSHUTT**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 3672/08(5)
DELIVERED ON:	20 May 2010
DELIVERED AT:	Cairns
HEARING DATE(s):	30 April 2010 & 19 May 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: death in custody, hanging points
REPRESENTATION:	
Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Kay Philipson

Table of Contents

The *Coroners Act 2003* provides in s45 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 specified officials with responsibility for the justice system. These are my findings in relation to the death of Andrew James Cockshutt. 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

Andrew James Cockshutt was found hanging in his cell at Lotus Glen Correctional Centre (LGCC) on the afternoon of 3 July 2008. He was 33 years of age and had spent the last 14 years of his life in custody. On occasion during that time he developed close relationships with other prisoners and was emotionally vulnerable to the break down of those relationships and prone to self harming. When such a scenario arose in early July 2008, as it had before, only some Corrective Services officers at LGCC were aware of his history in this regard.

These findings

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

- consider whether the likelihood of his impending death ought to have been evident to prison staff;

- consider whether any changes to procedures or practice at LGCC 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 Mark Tunny of the QPS Corrective Services Investigation Unit (CSIU) was assigned to conduct an investigation into the death. He flew to Cairns the day after being notified of Mr Cockshutt's death and took over the investigation from local police. Scenes of crime officers had already attended the cell in Unit B4 at LGCC where the body of Mr Cockshutt had been found prior to the arrival of Detective Sergeant Tunny. That cell and the surrounding area had been photographed and a thorough forensic examination of the cell conducted. No evidence suggestive of violence or an altercation of any sort was found. No relevant CCTV footage was available.

Statements were taken from all relevant Corrective Custodial Officers (CCO's) and information was gathered from prisoners in units B4 and B7 at LGCC. Detailed statements were taken from two prisoners who spoke to Mr Cockshutt in the 24 hours prior to his death.

All custody and medical records pertaining to Mr Cockshutt were seized along with documents found in his cell. Recordings of telephone calls made by Mr Cockshutt were obtained and examined for relevant material.

Records relating to the medical response that took place when Mr Cockshutt was discovered in his cell were obtained as was the related QAS documentation. Fingerprint analysis was conducted on the body of the deceased which confirmed a match with the record held by the QPS for Andrew James Cockshutt.

At the conclusion of his investigation Detective Sergeant Tunny formed the view that there was no evidence to conclude that any other person had caused or contributed to the hanging of Mr Cockshutt.

I find that the investigation into this matter was professionally conducted and I thank Detective Sergeant Tunny for his efforts.

A Queensland Corrective Services (QCS) investigation was instigated following the death of Mr Cockshutt using the services of a departmental and an external investigator. This resulted in the production of an extensive report which was tendered at the inquest. The investigation appears to have been conducted in an impartial and appropriately critical manner. The recommendations made are appropriate and useful in addressing the findings that were made.

The Inquest

In accordance with the requirement of the Act, an inquest was held into the death of Mr Cockshutt. The inquest was held in Cairns on 19 May 2010. Oral evidence was taken from the investigating officer, the General Manager of Custodial Operations for the Department of Community Safety (DCS) and the Director Correctional Infrastructure Management Branch, DCS.

All of the statements, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Counsel assisting submitted that I was unlikely to be assisted by the calling of any further oral evidence.

I determined that the evidence contained in the material tendered and the further evidence provided by way of oral evidence was sufficient to enable me to make the findings required by the Act. I am satisfied that the scope of this evidence was sufficient for me to adequately address those matters which might be appropriately considered under s.46 of the Act.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal and custodial history

Andrew James Cockshutt was born in Papua New Guinea on 24 February 1975 and adopted at the age of three. His adoptive parents moved with him to Darwin six years later and he attended school there until grade 10. At the age of 15 he took the decision to move to Mareeba with an indigenous family with whom he had become close. He completed year 10 and worked intermittently for several years.

On the evening of 29 January 1994 at the age of 19, Mr Cockshutt was drinking with a group of friends when he became involved in a fight during which he killed another man. He was found guilty of murder and sentenced to life imprisonment.

In March 2007, shortly after becoming eligible, he applied for parole but was refused on the basis that he continued to pose an unacceptable risk to the community.

Mental health and prison relationships

Mr Cockshutt was not diagnosed as suffering from any psychiatric disorder while in custody at Lotus Glen. It had, though, become known to prison staff that Mr Cockshutt had a tendency to become emotionally attached to other prisoners. This resulted in the development of a more serious sexual relationship with a particular prisoner in 2002. On that other prisoner being released, a CCO was sufficiently concerned by the effect of this on Mr Cockshutt's mental state that he was identified as being at risk of self-harm. A reported notification to that effect was completed on 5 December 2002 by a senior psychologist after the matter had been referred to her.

On 21 September 2006 Mr Cockshutt was found to have inflicted a 25mm cut to his left wrist region. He was noted as showing signs of depression and placed under observation before being released back into the general prison population in October 2006. He was given Diazepam on the two days after discovery of his injury but no ongoing medication or treatment was determined necessary for depression. The catalyst for this incident appears to have been difficulties associated with a relationship he had formed with a fellow prisoner. This incident was recorded on the computerised Integrated Offender Management System (IOMS) by then being used by QCS.

No further incidents of note concerning Mr Cockshutt are to be found on his file.

Transfer to Unit B7

The material presented at the inquest reveals that Mr Cockshutt had made requests from mid 2007 onwards to be re-located closer to a prisoner with a view to re-commencing their relationship which had been interrupted by the other prisoner's release from custody. As part of the DCS investigation the General Manager of the prison was interviewed on this issue. He told investigators that he had refused the application due to the apparent presence of documentation suggesting the other prisoner was fearful of Mr Cockshutt. This documentation could not be located when sought by investigators and is

not corroborated by any other evidence. In any event it would seem that the General Manager would have been entitled to refuse the application without having to rely on such reasoning.

After the other prisoner returned to custody in 2007 he was housed in unit B7. The Accommodation Manager, Michael Gleave says he then began to receive regular requests from Mr Cockshutt to be moved into that unit as he "wanted to be in a relationship". Although Mr Gleave was aware of the circumstances of Mr Cockshutt's 2006 self-harm episode he eventually relented and approved a move for Mr Cockshutt from unit B4 to B7. The move took place on 30 June 2008. There is no suggestion that the other prisoner raised any concerns to QCS staff as a result.

Incident logs seized from Unit B7 show that at least one other prisoner did raise a concern. Michael Harries, a prisoner in unit B7 was a nephew of the person whom Mr Cockshutt was convicted of murdering in 1994. Shortly after Mr Cockshutt arrived in Unit B7 a prisoner, most likely Mr Harries approached a CCO to advise that "*Cockshutt is hated and no one wants him in the unit*".

On 1 July 2007 Mr Cockshutt disclosed to another prisoner in the unit, Timothy Bennett that the other prisoner had broken off their relationship and that he had "slashed" himself as a result. Early on the morning of 3 July 2007 Mr Cockshutt entered Mr Bennett's cell and revealed slash marks on his left wrist. Mr Bennett says he got bandaids from one of the CCO's. He was sworn to secrecy by Mr Cockshutt who feared that any revelation of his self-harm would see him put under observation; a situation he apparently wished to avoid.

At 9:15am that morning Mr Cockshutt approached a CCO and advised that it wasn't "working out" in Unit B7. He requested a transfer back to Unit B4. An email request was put through to the Accommodation Manager and on this occasion Mr Greave approved the transfer within 30 minutes. He did not make any further enquiry as to the reasons for the move.

Mr Cockshutt was returned to Unit B4 shortly after 10am. He was processed by the CCO monitoring that unit, Michelle Butler. She recalls that he appeared to be in a good mood and was not upset.

Return to Unit B4

Shortly after his return Mr Cockshutt spoke to another prisoner, Richard Dixon. He related to Mr Dixon the fact that the other prisoner had broken off their relationship and that he was "pretty upset". Mr Cockshutt later revealed the cut to his wrist. Although Mr Dixon offered words of encouragement in relation to the break up, he did not consider reporting the cut wrist to any other person.

At 12:35pm Mr Cockshutt left Unit B4 to go to the medical centre where he presented complaining of a headache. He was given two painkilling tablets and returned at 12:40pm. The nurse who attended on him, Jane Donaldson,

provided a statement to the effect that Mr Cockshutt appeared normal in his demeanour and was not noticeably anxious or depressed.

CCO's Lyons and Butler commenced a walk through of Unit B4 at 12:54pm. CCO Lyons had been at LGCC long enough to be aware of Mr Cockshutt's history of relationships and the trauma caused when they ended. He was aware of the movements between Unit B4 and Unit B7 and was concerned enough that when he saw Mr Cockshutt on the round he enquired as to how he was feeling.[1] Mr Cockshutt appeared cheerful to CCO Lyons and showed no signs of being depressed. CCO Lyons asked him if he was happy being back in Unit B4 to which he replied; "*Yeah it's good to see some of the boys. I like it here"*. The observation that Mr Cockshutt was either cheerful or at least not noticeably upset or depressed was consistent with all other observations of him through the morning.

The conversation with CCO Lyons was the last known conversation that Mr Cockshutt had. He was last seen cleaning his cell at around 1.00pm by another prisoner.

Discovery of Mr Cockshutt and medical response

Just before 3.00pm CCO Vicky Jones entered Mr Cockshutt's cell. She did so in the course of escorting two plumbers to fix a leak complained of by an earlier occupant of the cell. She had to unlock the door to enter and on doing so she observed Mr Cockshutt to be hanging from bed sheets tied to a towel rail. The rail was a permanent fixture attached to the wall 150cm above the ground.

CCO Jones sent the plumbers out of the unit and immediately called a code blue. She then attempted to cut Mr Cockshutt down and was successful in doing so with the assistance of CCO Lyons. QAS were called and their records show this occurred at 3:04pm.

CCO Lyons noted that Mr Cockshutt's airway was clear but that he was not breathing and had no pulse. He commenced CPR and this continued with the assistance of other LGCC staff until the arrival of QAS officers at 3:22pm. The nurses arrived within minutes of the code blue being called and attached a defibrillator to Mr Cockshutt, however, it immediately indicated "*no shock advised".* The nursing staff noted that Mr Cockshutt was cold to the touch and his pupils were dilated. It was sadly evident to paramedics shortly after arrival that Mr Cockshutt was unable to be revived and he was declared deceased at 3:29pm.

The QCS investigation into the incident revealed that LGCC had no local "Contingency policy" in place at the time of the incident. This policy regulates, inter alia, what is to occur on the calling of a "code blue". I am satisfied that this did not adversely effect the quality of the response to Mr Cockshutt once

[1] CCO Lyons also gave evidence that he reported his concerns to his immediate superior although that officer was unable to recall any such conversation.

he was discovered hanging in his cell and that everything possible was done to assist him. I note that a local policy is now in place.

Autopsy results

An autopsy examination was performed on 4 July 2008 by an experienced forensic pathologist, Paull Botterill, in the mortuary at Cairns Base Hospital.

He later examined toxicology and histological findings before preparing a detailed report. The toxicology results were consistent with the headache medication taken by Mr Cockshutt in the hours before his death and were otherwise unremarkable.

Dr Botterill found:

> *The cause of death was hanging and the features at post-mortem examination were consistent with self inflicted injury*.

He found no evidence consistent with Mr Cockshutt having been assaulted.

He issued an autopsy certificate listing the cause of death as hanging.

Conclusions

I find that Mr Cockshutt intentionally took his own life while distressed about a relationship breakdown. No other person was involved in his death.

I am satisfied that, notwithstanding the incidents involving Mr Cockshutt in 2002 and 2006 described earlier, the circumstances on the morning of 3 July 2008 were not such that any staff member at LGCC ought reasonably have been aware that he was likely to take his own life that day.

I am also satisfied that the staff of the LGCC acted promptly and appropriately when Mr Cockshutt was found hanging. They are to be commended for their actions.

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 Andrew James Cockshutt.

How he died – Mr Cockshutt hung himself with bed sheets tied to a towel rail in his prison cell. He did so shortly after the break down of a relationship with another prisoner with the intention of ending his life. No other person was directly involved in the hanging.

Place of death – He died whilst in the custody of the Department of Corrective Services at Lotus Glen Correctional Centre.

Date of death – Mr Cockshutt died on 3 July 2008.

Cause of death – He died from the effects of 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.

There are two aspects of this case which warrant consideration from that perspective, namely:-

- The monitoring of intra-prison relationships; and
- The presence of hanging points in cells.

Monitoring of intra-prison relationships

The QCS 'At-Risk' procedure was in place at LGCC in July 2008. It requires that self-harm/suicide risk assessments *must* be undertaken in certain circumstances. These circumstances include situations in which QCS officers become aware of particular events in a prisoner's life that may elicit self-harm or attempted suicide. A "*Periods of Critical Risk*" list is appended to the procedure document to assist officers in applying the requirements of the procedure. That appendix makes specific reference to "*relationship breakdown*".

This raises the question why was it not followed or implemented in this case. The answer lies in the following findings of the QCS commissioned report into the death:

> *Other than the 'corporate knowledge' held by certain officers, the previous warnings and details about specific incidents (2002 and 2006) could only have been identified by review of prisoner Cockshutt's (large) case file……Overall, it reflected poor (past) practice in relation to information management, particularly around information that would have warned against the placement of prisoners Cockshutt and -------- together in the same unit.*

The Integrated Offender Management System (IOMS) used by QCS allows all QCS officers to access certain information on all prisoners. Since late 2006 this has included a facility whereby prisoners who have self-harmed are specifically noted and their file electronically flagged so that it is immediately

clear to anyone inspecting the record. When this process was implemented it applied only to prospective incidents. It did not, therefore, flag that Mr Cockshutt had previously self harmed or that he had been identified as being at risk in 2002 and 2006. Although the second of these incidents occurred in September of 2006 and was recorded on IOMS, it appears to have just missed being caught by the new system whereby such incidents result in the prisoner's record being specifically flagged.

The evidence establishes that some QCS officers on duty on 3 July 2008 knew of Mr Cockshutt's prior episodes of self harm; but many didn't, including those in charge of units B4 and B7 on the relevant day. The only way they might have learned of this information is by word of mouth or by the unlikely process of them trawling through Mr Cockshutt's custodial file or IOMS entries.

Mr Scott Collins, General Manager Custodial Operations DCS gave evidence outlining a process commenced in 2009 in which all prisoners in custody prior to the implementation of the self-harm recording process (and not already caught by the process) were interviewed and their records checked for any incidents of self harm. This procedure, if adopted prior to Mr Cockshutt's death would have caused him to be flagged on the IOMS system. There is no guarantee that this would have changed the outcome for Mr Cockshutt, however, I accept that it is an appropriate response to the information recording deficiency that was brought into sharp relief by his death.

Mr Collins also gave evidence that amendments have been made to QCS policy concerning the collection of intelligence information. This now specifically requires intelligence officers to note information regarding prisoners who may be incompatible for accommodation purposes.

I am satisfied that these policy responses by QCS to the 'at-risk' issues arising from the death of Mr Cockshutt obviate the need to make any further recommendations

Access to hanging points

The Royal Commission into Aboriginal Deaths in Custody (RCADIC), in its final report recommended hanging points be eliminated from watch houses and prison cells. The State Government accepted that recommendation and committed to implementing it.

Official statistics incontrovertibly prove that prisoners as a group are at far greater risk of suicide than the general population. As this case demonstrates, mechanisms for assessing the degree of risk for individual prisoners are far from fool proof. It is therefore incumbent on authorities who have a duty to care for prisoners to do all that is reasonable to reduce the general risk.

Research has repeatedly shown that any interference with an opportunity to commit suicide can deter and prevent other attempts succeeding.

As I have done in earlier inquests, I again urge the Department to take the obvious steps that are required to make the cells in which they house prisoners safe for that purpose.

In relation to the specific arrangement in place at LGCC the inquest heard evidence from Mr John Forster, Director Correctional Infrastructure Management Branch for the DCS. I accept his evidence that the elimination of hanging points is a priority for the DCS but that it is one limited by the need to allocate limited financial resources. Mr Forster explained the details of the extensive re-development of LGCC that commenced in 2008 and is to be completed by 2012. I am advised that this program of works is on time and on budget.

I accept the evidence that the block in which Mr Cockshutt was housed (built in 1988) can not be re-developed while prisoners are still housed in it. The inquest was told that the first stage of the re-development of LGCC in which a number of new cells are to be built, must be completed before the shortcomings in these older cells can be addressed. It is expected prisoners will be transferred to the new cells once stage 1 of the re-development is completed in 2011. The existing cells will be brought up to an acceptable standard by 2012.

Mr Forster also gave evidence of testing which has been conducted on methods to eliminate hanging points in older style cells, such as those in which Mr Cockshutt was housed, where the windows are covered by horizontal bars. The effect of that evidence was that any modification that is effective for security purposes would not allow sufficient ventilation and airflow for the cell to be habitable. The only solution to this problem is the installation of air conditioning. It is the implementation of air conditioning at Lotus Glen that requires the re-housing of prisoners; hence the unfortunate length of time before changes will be made.

I retain concerns about the unnecessarily high positioning of the towel rail which Mr Cockshutt used to hang himself. The logic applied by DCS is that the inability to securely change the current layout of the cells, wherein they contain horizontal bars over the window, and thus an obvious hanging point, means it would be futile and a waste of resources to eliminate any or all other potential hanging points. I accept that as a reasonable argument. I nonetheless maintain that this is an issue that ought to have been resolved long before now. I draw on the many previous recommendations made over many years in this jurisdiction on this issue in support of that contention.

Notwithstanding the efforts that are now being made, the evidence establishes that numerous prisoners have died because of the failure of successive State Governments to implement the recommendations of the RCADIC made and accepted 20 years ago.

I will refrain from making any further recommendation recognising that it will not speed up the process at LGCC and that DCS is apparently well aware of the importance of the issue.

I close the Inquest.

Michael Barnes
State Coroner
Cairns
20 May 2010