OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jason Andrew MUIR**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 00005738/08(3)
DELIVERED ON:	31 August 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	6 July 2010 & 5 August 2010
FINDINGS OF:	Ms Christine Clements, Acting State Coroner
CATCHWORDS:	CORONERS: death in custody, hanging points, medication non-compliance

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Kay Philipson
Queensland Health:	Mr Kevin Parrot
GEO Australia Pty Ltd:	Ms Kerri Mellifont (instructed by Blake Dawson Lawyers)

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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 Jason Andrew Muir. 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

Jason Muir was found hanging in his cell at Arthur Gorrie Correctional Centre (AGCC) in the early hours of 25 September 2008. He was 36 years of age and had spent much of his adult life in custody. Several months prior to his death Mr Muir had exhibited suicidal ideations but by June 2008 was considered sufficiently well to join the general prison population. This improvement correlated with the prescription of gradually increasing doses of anti-psychotic medication. On the day prior to his death, as on some other occasions, Mr Muir had not taken his medication.

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 AGCC 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 Acting Sergeant Justin Webb of the QPS Corrective Services Investigation Unit (CSIU) investigated the death of Jason Muir.

He travelled to AGCC with other CSIU officers on 25 September 2008 after being notified of Mr Muir's death and took over the investigation from local police. Oxley scenes of crime and photographic officers had already attended the cell in Unit A4 at AGCC where the body of Mr Muir had been found. The cell and the surrounding area had been secured as a crime scene and photographed with Mr Muir in situ. A thorough forensic examination of the cell had been conducted. No evidence suggestive of violence or an altercation of any sort was found and this was consistent with the observations of Acting Sergeant Webb on his arrival.

Statements were taken from all relevant Corrective Custodial Officers (CCO's) and all custody and medical records pertaining to Mr Muir were seized along with documents found in his cell. CCTV footage covering the hallway of Unit A4 and of cell 22 was seized and viewed by police.

Interviews were conducted with all prisoners in unit A4 at the time of Mr Muir's death. Records relating to the medical response that took place when Mr Muir was discovered in his cell were obtained as was the related QAS documentation. The deceased was formally identified by his mother at the John Tonge Centre.

At the conclusion of his investigation Detective Acting Sergeant Webb drew the conclusion that no other person had caused or contributed to the death of Mr Muir.

I find the investigation into this matter was professionally and appropriately conducted.

A Queensland Corrective Services (QCS) investigation was instigated following the death of Mr Muir using the services of a departmental and an external investigator. This resulted in the production of a report which was tendered at the inquest and was helpful to me in identifying those areas of policy and procedure at AGCC requiring improvement.

The Inquest

In accordance with the requirement of the Act, an inquest was held into the death of Mr Muir. The inquest was held in Brisbane on 5 August 2010. Oral evidence was taken from the investigating officer and the acting clinical director for the Prison Mental Health Service (PMHS), Dr Andrew Aboud.

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 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. I have not summarised 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

Mr Muir is survived by his mother Janice Byrne and his brother Darren Muir. It is clear from the material before me, including the very detailed notes left behind in his cell that Mr Muir was very close to both of them. It is evident he was very much loved and is missed by both Ms Byrne and Darren.

Mr Muir's life should not be defined by the time he spent in custody but it is appropriate I address that issue. After reaching the comparatively late age of 19 before becoming involved in any crime of significance, Mr Muir was imprisoned for a period of 11 years in 1996 when he was 25 years of age. This followed convictions for numerous armed robberies and associated offences. Breaching the terms of his subsequent parole resulted in him serving the whole 11 years of the sentence.

After being released in early 2007, Mr Muir was again arrested in February 2008 on similar charges. At the time of his death he was still on remand for these alleged offences. It can be inferred from information of conversations with prison staff that Mr Muir was resigned to facing a further lengthy term of imprisonment for the most recent charges.

Mental health history and treatment

Mr Muir came under the care of the PMHS when triaged by a PMHS clinician shortly after arrival at AGCC on 21 February 2008. On 28 February 2008 he was assessed by a psychiatrist and prescribed psychotropic medication. Initially he was experiencing auditory hallucinations.

On 27 March 2008 Mr Muir was assessed by prison staff as being a prisoner 'at risk' of self harm. He was exhibiting clear suicidal ideation at this time and records show this continued in varying degrees over the course of the following two months. Specific note is made of an attempt to starve himself as it was the only way to kill the 'devil' inside him.

The 'at risk' status assigned to a prisoner draws that person into the supervision of a risk assessment team (RAT) which consists of PMHS, Offender Health Service (OHS) and other staff. That team is charged with the responsibility of conducting regular reviews of the prisoner's status by way of a risk review. A conservative approach is adopted by the team in assessing whether there should be any downgrade in the level of risk (and therefore the extent to which the prisoner should be observed). A management plan is developed for the prisoner at each review.

After an initial risk review Mr Muir was placed on 30 minute observations but these were increased to 15 minute intervals on 31 March.

Mr Muir remained under observation over the course of the following months until 12 June 2008. The interval of observation was gradually reduced. This coincided with a gradual increase in his prescribed medication. His mood and outlook also improved during this period.

Mr Muir was seen by various PMHS psychiatrists on a regular basis between March and June 2008. When seen on the second occasion on 20 March 2008, Dr Mann changed the dosage of the prescribed medication of anti depressant Mirtazapine (Avanza) and anti psychotic Quetiapine (Serequol).

Overall I accept the proposition by Dr Aboud that Mr Muir received a good standard of mental health care, and possibly of a higher standard than he

might have accessed had he not been incarcerated. It cannot however be overlooked that incarceration itself is a circumstance documented to elevate the risk of suicide.

Removal from observation and transfer into a cell which was not suicide resistant

On 12 June Mr Muir's 'at risk' status was removed and he was returned to the mainstream prison population. This followed his gradual re-integration into the general prisoner population commencing with spending the day in his new unit while being returned for observation at night over a period of weeks.

The decision of the RAT to return Mr Muir to the general prison population was based on an apparent improvement in his outlook, the absence of reported suicidal ideation and the seeming effectiveness of his increased level of medication.

Mr Muir was reviewed by a PMHS psychiatrist on 26 June 2008. At this time it was recorded by the psychiatrist he had transitory thoughts of suicide but no intent or plans. On 28 August 2008; he reported improved sleep and appetite and the absence of distressing thoughts or suicidal plans. A further appointment was made for 9 October 2008.

After returning to the general population Mr Muir was initially housed in unit B5 and then W1. These are newer blocks which might be considered 'suicide resistant' at least in relation to some of the older style blocks at AGCC.

Following an altercation involving another prisoner on 21 August 2008, Mr Muir was transferred to cell 22 in Unit A4. That cell was by no means suicide resistant. There were exposed and accessible horizontal bars in the space above the cell door which provided ventilation to the cell. The bars also provided an anchor point for a noose created from strips of sheeting. Disassembled disposable razors were discovered in Mr Muir's cell.

Evening of 24 September 2008

At 6:01pm on the evening of 24 September 2008 all prisoners in unit A4 at AGCC were locked in their cells. CCTV footage confirms the statements of the CSO's that this occurred and no one accessed the cell until after the discovery of Mr Muir's body.

In accordance with procedure at AGCC, headcount and welfare checks of the prisoners took place at 3 hourly intervals thereafter. At 1:53am the following morning Mr Muir was observed by CSO's during a headcount with nothing suspicious being noted.

It is now known that sometime that evening Mr Muir fashioned a noose and a strip of cloth used to bind his hands together. These were prepared with the initial "cutting" of the bed sheet with a disassembled razor blade. At some time after 1:53am he secured the noose to the exposed horizontal railings above his cell door and around his neck, tied his hands together and stepped

through his bound hands so they were secured behind his back. He pushed away from the cell chair and slumped downwards so as to tighten the noose.

CCTV footage confirms Mr Muir was locked alone in his cell at 6:01pm the previous evening and no one accessed that cell until shortly after 4am the following morning.

Discovery of Mr Muir and medical response

At 4:01am CSO McLaren was conducting a further headcount in Unit A4 when he noticed that newspaper had been secured over the window of cell 22. He then noticed the sheet tied to the horizontal bars and on feeling it could tell a significant weight was attached.

CSO McLaren immediately notified correctional supervisor Peter Henderson, the Area Manager, who directed him to obtain the cell keys. As he was doing this, CSO McLaren called a 'code blue' over his radio initiating the AGCC medical emergency response. After accessing the cell Mr Henderson cut the noose using CSO McLaren's "cut down" knife and then cut the material securing Mr Muir's hands.

Cardio Pulmonary Resuscitation was immediately commenced by those officers before this task was taken over by prison medical staff. Qld Ambulance Service was notified at 4:14am and immediately dispatched. They arrived at Mr Muir by 4:31am. Sadly it was apparent, even to the prison officers who initially found Mr Muir, that he had been deceased for some time and he was unable to be revived.

Mr Muir was declared deceased at 4:39am by paramedic Alex Thompson.

Results of Investigation

A review of the CCTV footage seized from AGCC confirmed all other evidence suggesting Mr Muir's death was not caused by any other person.

Investigating police provided the letters found in Mr Muir's cell to his mother Ms Byrne, who immediately recognised them as being written in her son's handwriting. She was able to produce another letter written by Mr Muir some years earlier that confirmed her opinion it was her son's handwriting. The letters evidence a clear intention by Mr Muir to take his own life and the degree to which he regrets this decision would hurt his mother.

A review of Mr Muir's medication records show he did not obtain his prescribed medication on 24 September 2009. The same medication chart shows there were previous occasions, although rare, when Mr Muir had missed his medication. The failure to take his medication on 24 September 2009 was not reported and there was no requirement on staff to do so. Relying on the expert psychiatric evidence of Dr Aboud, I am satisfied there is no causal link between this issue and Mr Muir's death but will address the possible implications arising from non-compliance with prescribed medication later in these findings.

Autopsy results

An external autopsy examination was performed on 27 September 2008 by an experienced forensic pathologist, Dr Kathy Urankar at the John Tonge Centre.

Dr Urankar later examined toxicology findings before preparing a detailed report. The toxicology results were consistent with the medication prescribed to Mr Muir; the low dosage of Quetiapine (Serequol) being consistent with his failure to take that medication on the day prior to death.

Dr Urankar observed an "…*indentation involving the almost the (sic) entire circumference of the neck*". Apart from this no external evidence of trauma was found. Dr Urankar opined that the cause of death could be in keeping with hanging. No external evidence consistent with an alternative cause of death was evident.

Although Dr Urankar was aware generally of the circumstances in which Mr Muir was found, it is clear from her report she considered it necessary to perform a full internal autopsy in order to exclude other possible causes of death. On this basis an autopsy certificate was issued listing the cause of death as "*undetermined"*.

I have the benefit of examining the detailed evidence, the important aspects of which I have set out above. On this basis, and the findings of Dr Urankar, I am able to confidently reach the conclusion that the cause of Mr Muir's death was the effects of hanging and no other person was involved in this process. I am satisfied the order made by the State Coroner that the autopsy examination should be external only was entirely appropriate given the totality and strength of the evidence that was available even at an early stage. I also note the potential distress more intrusive forms of autopsy examination can cause to family of the deceased.

Conclusions

I find that Mr Muir intentionally took his own life and he did this by fashioning a noose and hand restraint from strips of bed sheeting. It is most likely he used dismantled safety razors to assist in the cutting of the sheeting.

I am satisfied that, notwithstanding his extensive psychiatric history, the circumstances on the morning of 25 September 2008 were not such that any staff member at AGCC ought reasonably have been aware he was likely to take his own life that day. In hindsight it is clear Mr Muir carefully planned his own death including the preparation of letters to family members, masking of the cell window, preparation of the noose and hand bindings and the physical act required to culminate his intention to end his life. Mr Muir performed these actions in an interval of time between physical checks when he could expect he was unlikely to be discovered or interrupted.

I am also satisfied the staff of AGCC acted promptly and appropriately when Mr Muir was found hanging.

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 Jason Andrew Muir

How he died – Mr Muir hung himself using torn bed sheets tied to an exposed bar above the door of his prison cell. 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 Arthur Gorrie Correctional Centre.

Date of death – Mr Muir died on 25 September 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 aspects of this case which warrant consideration from that perspective, namely:-

- The monitoring and reporting of non-compliance by prisoners with the taking of prescribed medication;
- The management and housing of prisoners with an 'elevated base level' of risk; and
- The presence of hanging points in cells.

Monitoring and reporting of medication non-compliance

I have indicated I accept the evidence of Dr Andrew Aboud that no causal link can be inferred from Mr Muir's failure to take one dose of his medication and his subsequent suicide.

I also note Mr Muir was perfectly entitled to decline medication as he was not subject to the constraints of the Mental Health Act. There was nothing to suggest he should have been.

I note the newly introduced workplace instruction which has introduced a regime of automatic referral and review of a prisoner who declines medication

for a period of three days. If this occurs the information must be referred to the Offender Health Service. Dr Aboud noted this is a somewhat arbitrary time trigger and there is a specific medication exception which must be notified immediately if declined due to the higher risk of serious physical or mental health adverse impact (clozapine). The Prisoner Mental Health Service routinely reviews a prisoner's chart which will record any medication non compliance and be discussed in the regular inter disciplinary team meetings which occur three times per week.

I note the newly introduced workplace instruction for the Offender Health Service is being implemented state wide.

Prisoners with an elevated base level of risk

At the time of Mr Muir's most recent incarceration there was no specific requirement that those identified as being at an elevated base level of risk (of self harm) be housed in the newer, suicide resistant cells.

Subsequently a process for managing offenders with elevated base line risk of self harm has been developed. Evidence was provided through a report from the General Manager of Arthur Gorrie Correctional Centre, Gregory Howden.

I am satisfied there is now in place a policy and procedure to identify those offenders with an elevated baseline risk at Arthur Gorrie Correctional Centre. Prisoners are assessed and identified and then recorded on a register. A multi disciplinary team reviews their risk monthly. The review involves psychologists, health services, custodial operations and an Aboriginal and Torres Strait Islander representative where appropriate. Most importantly, such prisoners are to be accommodated appropriately to reduce the risk of self harm.

Unfortunately, in this instance Mr Muir was moved to a cell which had not been renovated and still had access to a visible hanging point.

There is of course a propensity for many prisoners at AGCC to have elevated baseline risk due to its nature as a remand and reception prison. This highlights the importance of the next issue of reducing the physical accessibility of ready hanging points.

Access to hanging points

In recent findings the State Coroner made the following comments-

> *"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 the 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."*

I endorse the comments of the State Coroner.

In relation to the specific arrangements in place at AGCC the inquest was provided with 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 it is one limited by the need to allocate limited financial resources.

Mr Forster's statement informed the inquest of testing which has been conducted on methods to eliminate hanging points in older style cells, such as those in which Mr Muir was housed, where the cells contain 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 and this would require re-housing of prisoners as well as substantial capital expenditure.

Mr Forster explained there are 380 cells at AGCC that would need modification to make them suicide resistant. This would involve the installation of air-conditioning, the removal of louvers and the installation of toughened glass. It would require re-housing of prisoners and cost in the order of $50m. I I am advised by Mr Forster that alternatives to such major works continue to be explored.

Although this evidence is accepted, I again adopt the comments of the State Coroner addressing a similar set of circumstances-

> *"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."*

When I commenced hearing this inquest I recalled one of the first inquests I conducted. It was an inquest into a death in custody of Denis Donald Fountain who died on 17 May 2001.

Mr Fountain died due to hanging in cell block A3 at Arthur Gorrie Correctional Centre. He formed a noose with strips from a towel. He used a disposable razor to cause superficial cutting injury to his elbows. He secured the noose to the exposed bar above his cell door.

In that inquest I made the following comment;

> "*There have been numerous deaths in custody in this state and throughout Australia. The issues have been identified and recommendations made repeatedly, and at the highest levels of judicial comment. In particular, the Royal Commission into Aboriginal Deaths in Custody made specific recommendations. The deaths continue.*
>
> *It is accepted that a person intent upon self harm may be very difficult to protect. But there are obvious and basic physical issues to be addressed as a matter of urgency. Otherwise, further coronial comment and recommendation is of no value in seeking to prevent deaths in the future*."

I thank those participating in this inquest for their assistance. I extend sincere condolences to the family of the deceased, Jason Andrew Muir

I close the Inquest.

Christine Clements
Acting State Coroner
Brisbane

31 August 2010