QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mark Walter DAY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR/03 2742
DELIVERED ON:	19 December 2006
DELIVERED AT:	Brisbane
HEARING DATE(s):	18 May 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, murder, supervision of dangerous prisoners
REPRESENTATION:	

Counsel Assisting:	Detective Inspector Gil Aspinall
Department of Corrective Services:	Ms Annie Little

Findings of the inquest into the death Mark Walter Day

Table of contents

The *Coroners Act 1958* provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of Mark Walter Day.

Introduction

On 3 October 2003, Mark Walter Day an inmate at the Sir David Longland Correctional Centre died as a result of a violent prolonged attack by a prisoner who had previously been convicted of murdering another prisoner. The attacker has since been convicted of Mr Day's murder. These findings seek to explain how the death happened, consider whether any other persons should face criminal charges in connection with the death and consider whether any changes are needed to prison policies or procedures to reduce the likelihood of deaths occurring in similar circumstances in future.

The coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Although the inquest was held in 2006, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the police officer who first became aware of the death considered it to be "*an unnatural death*" within the terms of s7(1)(a)(i) of the Act, and as Mr Day was in custody when he died, the officer was obliged by s12(1) to report it to a coroner. Section 7(1) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred; and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths occurring in future. As a result, the Act authorises a coroner to make preventive recommendations referred to as riders. However, a coroner must not frame his or her findings or any comments in such a way as to appear to determine any question of civil liability or as to suggest that any person is guilty of a criminal offence.[2]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit*" provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[3]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[4] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[5]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[6] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[7] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(6)
[3] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[4] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[5] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[6] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[7] (1990) 65 ALJR 167 at 168

The investigation

I turn now to a description of the investigation into this death. Soon after Mr Day was found deceased Detective Sergeant Phillip Notaro of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a comprehensive coronial investigation.

All relevant witnesses were interviewed and statements obtained and exhibits collected. On 9 October 2003, an autopsy was conducted by Dr Beng Ong, a Forensic Pathologist, at the John Tonge Centre Mortuary.

A comprehensive crime scene examination was undertaken by forensic officers.

I am satisfied that the investigation into this death was competent and thorough.

The inquest

An inquest was opened in Brisbane on Thursday, 18 May 2006. Detective Inspector Aspinall was appointed to assist me. Leave to appear was granted to the Department of Corrective Services. All of the statements, records of interview, medical records, photographs, police reports and Department of Corrective Services investigation reports and materials gathered during the investigation were tendered into evidence.

Some weeks before the inquest was opened a copy of the police investigation report was provided to Mr Day's mother Mrs Theresa Wallwork. After the family had an opportunity to consider that material, his mother, advised the court that neither she nor any other family member wished to attend the inquest and there were no matters they wished to raise for investigation. The family indicated that they did not wish to challenge versions contained in the documents, which had been tendered, nor cross-examine any of the witnesses.

Having considered all of that material and having regard to the criminal prosecution, industrial and disciplinary action that has been taken in connection with the events surrounding the death of Mr Day which I detail later in these findings, I have come to the view that no good purpose would be served by hearing any oral evidence. The factual circumstances of the death have been established beyond reasonable doubt and remedial action has been taken to address systemic failings that had allowed the death to occur. I consider that the evidence contained in the tendered material is sufficient to enable me to make the findings required by the Act and that there is no other purpose which would warrant any witnesses being called.

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.

Background

First, I wish to acknowledge the assistance I received from a document kindly provided to me by Mr Day's mother entitled "Extract of a Report on the History and Life of Mark Walter Day." It gave me some insight into Mr Day's early life.

His mother and father separated when he was only seven years of age. According to his mother, Mr Day's father had minimal contact with them. She believes this had a profound affect upon their son.

He has a brother and a sister, who continued to be close and supportive of Mr Day throughout his life.

Once he reached adolescence, his conduct changed quite dramatically and he commenced to regularly run away from home and became virtually uncontrollable. Mr Day had a loving, respected and supporting family in his mother, brother and sister, however they were unable to persuade him to change his antisocial ways.

Mr Day's criminal history began in 1989 when he was sixteen years of age. He was convicted of property offences and placed under Care and Control of the Family Services Department for two years, with strict custody for three months.

During 1991, he received further convictions in relation to property and robbery offences, receiving a six month term of imprisonment.

On 28 January 1992, he was convicted of further property offences and was sentenced to seven years imprisonment. He remained in custody for the remainder of his life.

On 12 September 1994 Mr Day murdered a fellow prisoner Nguyen Dung VAN at the Lotus Glen Correctional Centre. On 1 March 1995, he was convicted of the murder and sentenced to life imprisonment.

On 12 September 1997, Mr Day murdered another prisoner, Scott Lawrence Topping at the Woodford Correctional Centre. On 29 February 2000, he was again sentenced to life imprisonment with a minimum of twenty-five years to be served.

As a result, he was not eligible for parole until 28 February 2025.

Events leading up to the incident

Due to his convictions for the murders of two prisoners, Mr Day was accommodated within the Maximum Security Unit (MSU) at the Sir David Longland Correctional Centre at Wacol, Brisbane.

Jason John Nixon was housed in the same unit. He too had been sentenced to life imprisonment for the murder of a fellow prisoner and he was eligible for parole on 23 November 2014.

Mr Day and Mr Nixon were allowed to associate for two (2) hours a day in the exercise yard between 9.00am and 11.00am as part of an "approved association" under the provisions of each prisoner's Individual Management Plan.

The incident

The area where this incident occurred is monitored by video-surveillance cameras and, as a result, the entire incident resulting in Mr Day's death was captured on film.

On 8 October 2003, Mr Day and Mr Nixon were escorted separately to the exercise yard of C Wing shortly after 9.00am. This was a daily occurrence. There was no

indication leading up to this time that there was any animosity between them. There was no one else in the exercise yard and no one entered until after Mr Day was killed.

At approximately 10.48am, Mr Nixon and Mr Day were lying on the floor of the exercise yard sunbaking. There had been little or no interaction between them up until this stage. Mr Day was lying on his back on an exercise mat with his headphones on listening to his radio.

Mr Nixon is seen to get to his feet and commence a violent attack upon Mr Day as he lay on the ground. As Mr Nixon approached Mr Day, the video footage shows an object appearing on the ground, which was later identified as several bars of soap inside a brown prison issue sock. Mr Nixon later confessed to using the object to assault Mr Day.

Mr Nixon commenced punching and kicking Mr Day. Mr Day attempted to get to his feet, but he was punched and kicked back to the ground. Mr Nixon then commences to kick and stomp Mr Day in the region of his head and neck. He can be seen holding onto a punching bag suspended near Mr Day to maintain his balance.

At 10.51am Mr Nixon ceased kicking and stomping on Mr Day but he then proceeded to stand on Mr Day's neck and throat with one foot utilising his full weight. Mr Nixon remained standing on Mr Day's throat for six minutes.

At 10.57am, Mr Nixon removed his foot from Mr Day's throat and walked around the exercise yard, putting his shirt on. He then returned to Mr Day where he again stood on Mr Day's throat until 11.02am.

At approximately 11.02am, Corrective Services Officer McKay attended the exercise yard of C Wing to take Mr Day and Mr Nixon back to their cells. Mr McKay immediately discovered Mr Day's motionless and bloodied body on the floor of the exercise yard.

When Mr Nixon came to the door and placed his hands through the slot in order to be handcuffed he said to Mr McKay, "*Don't worry about him chief, he's dead*."

Mr Nixon was removed from the exercise yard and a short time later he spoke with Centre Services Manager Ian Eggins and stated, "*I had a problem with Day and it's all resolved.*"

Nurses Phillips and Suddes attended the exercise yard and attempted to resuscitate Mr Day. A short time later paramedics arrived at the scene and continued the resuscitation efforts. At 11.32am these ceased when it was ascertained that Mr Day was dead.

Doctor Beng Ong, a forensic pathologist attended the scene and examined Mr Day and declared life extinct at 3.50pm.

He conducted an autopsy examination on Mr Day's body at the John Tonge Centre Mortuary on 9 October 2003. He advised that, in his opinion, Mr Day died from "*pressure to the neck*". This is consistent with what is depicted on the video-surveillance footage.

An immediate investigation was commenced by the Corrective Services Investigation Unit into the circumstances surrounding this incident. As a result of that investigation, Jason John Nixon was charged with Mr Day's murder.

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased 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 Mark Walter Day

Place of death – He died whilst in the custody of the Department of Corrective Services at the Maximum Security Unit, Sir David Longland Correctional Centre at Wacol.

Date of death – He died on 8 October 2003

Cause of death – He died as a result of "pressure to the neck" whilst being murdered by prisoner Jason John Nixon.

The committal question

In this matter, I do not need to turn my mind to the question of whether I should commit any person for trial in relation to Mr Day's murder because on 1 October 2004 and Jason Nixon pleaded guilty to murdering Mr Day and was sentenced to an indefinite life sentence.

I find that no other person, apart from Jason John Nixon, directly contributed to Mr Day's death. I find also that although there are bases for concern about how some Department of Corrective Services officers discharged their duties, which I shall detail later, there is no evidence to suggest that the action of any correctional services staff directly contributed to Mr Day's murder to the extent that those failings could found charges based on criminal negligence.

Preventative recommendations

Section 43(5) of the Act prohibits a coroner from expressing any opinion on a matter outside the scope of the inquest except in a rider which is, in the opinion of the coroner, designed to prevent the recurrence of similar deaths.

Obviously, prisons are dangerous places due to their clientele. This is known to departmental officers and they have comprehensive policies and practices in place to reduce the risk men like Messrs Day and Nixon pose. Some analysis of why those arrangements failed to prevent those risks from eventuating in the death of

Mr Day is necessary to ensure any mistakes that may have been made are not repeated.

The circumstances of Mr Day's death requires inquiry into why he was placed alone in the company of a man known to have previously murdered another prisoner and why Mr Nixon was able to carry out his deadly attack on Mr Day which extended over 14 minutes without anyone intervening. Indeed no prison officers became aware of the attack until Mr Nixon told one of them that Mr Day was dead.

Internal investigation by independent Inspectors

The Department of Corrective Services appointed Messes Lincoln and Kruhse as inspectors for the purpose of conducting an internal investigation into the incident that focussed on these aspects of the death. Their report was of great assistance to me.

The inspectors found that the prison authorities were aware that Messrs Day and Nixon had associated together in other institutions before with no negative results. They were also of the view that Mr Day's behaviour was improving and that he had earned the right to associate with other prisoners in a very controlled and structured way and that this was an essential element of his progress towards being re-integrated back into the general prison population. Mr Nixon had been participating in programs designed to assist with his anger management issues and with compliance with prison discipline. He had also been associating with another prisoner with no reported incidents. There was no intelligence suggesting they posed any particular risk to each other. However, both were on high security orders because it was recognised that there was a high risk that they might inflict death or serious injury on other prisoners. In the circumstances, I am satisfied that even though there were competing pressures that militated against these two prisoner being allowed to associate, provided that contact was properly supervised I am of the view that it was reasonable for authorities to allow it.

Regrettably, that supervision, which was clearly called for, didn't happen. All areas of the MSU including the exercise yard were filmed by closed circuit video cameras that could be viewed from the MSU control room. It was the duty of the correctional officer manning that control room on the day in question, CSO Smith, to monitor activity throughout the MSU. All cameras could be switched to show on the monitors in front of him. At the material time there was only one area of the MSU, other than the exercise yard, that needed monitoring.

The video film of the control room shows that between 10.30 am and 11.02 am Mr Smith did not look at the monitor at all. Instead, he read magazines, looked in a note book and talked on the phone. He totally failed to discharge his duty to monitor the actions of Messrs Nixon and Day while they were in the exercise yard. No other officer could do this. While it can not be proven what would have happened had CSO Smith adequately discharge his duties and alerted other officers as soon as Mr Nixon attacked Mr Day, there is a strong basis for suspecting that the death may have been avoided.

It was also established that Mr Nixon was not searched in accordance with the relevant policies when he was moved from his cell into the exercise yard and that the entries in the search register indicating that he had been were false and made after the death of Mr Day had been discovered.

As a result of considering this evidence the inspectors made the following recommendations:-

- That the Department of Corrective Services give consideration to the commencement of show cause and/or disciplinary action against the officer who failed to adequately monitor the prisoners in the exercise yard.

- That the Department of Corrective Services give consideration to the commencement of show cause and/or disciplinary action against the officers who had failed to adequately search the prisoners and who made false entries in the search logs, and consider referring potential breaches by them of the *Corrective Services Act 2000* to the Queensland Police Service for further action.

- That the Department of Corrective Services consider conducting a full internal audit of the Maximum Security Unit, including a review of management, monitoring and reporting systems, with a view to accurately establishing what level of compliance currently exists within the unit with respect to legislation, policies and procedures.

- That the Department of Corrective Services consider a review of the current policies and procedures in place with respect to the operation of MSU's generally, with a view to developing and implementing policies and procedures that are more specific to MSU environments and prisoners, and which recognise the heightened security and management risks that MSU prisoners present.

- That the Department of Corrective Services consider a review of the policies and procedures relating to prisoner association, with a view to developing and implementing policies and procedures that incorporate a wider range of risk factors to be considered when determining whether it is safe for particular prisoners to associate with others.

I sought and was provided with a written advice from the Department of Corrective Services concerning what action it had taken in response to the inspectors' recommendations.

Disciplinary action was taken against all three officers referred to in the first two recommedaions. One was dismissed, one retired before the action could be resolved and one was formally reprimanded.

The QPS determined that insufficient evidence existed to commence a criminal prosecution against any of these officers.

An external audit of the management, staffing and operations of the maximum security units at Arthur Gorrie Correctional Centre and the Sir David Longland Correctional Centre was undertaken. This also included consideration of the maximum security units' operational procedures and the practices concerning prisoner association in this environment.

I note that the audit report was provided to Cabinet and therefore was not publicly released. However, an abridged version of the report was deemed suitable by Cabinet for public dissemination. The Department established an implementation steering committee and addressed the 52 recommendations of this report. An implementation report was subsequently provided back to Cabinet.

Two procedures incorporating the recommendations of the internal auditors were developed and published in August 2005. One of these procedures deals directly with the day-to-day operations of maximum security units, while the other concerns the making and review of a Maximum Security Order.

Understandably, these procedures have been deemed not for public release owing to the security implications of the public dissemination of this document.

I note that Section 17 of the Maximum Security Unit's procedures deal with the physical association of prisoners within the maximum security unit. This section of the procedure outlines the assessment and approval processes for prisoner association, as well as the monitoring of prisoners whilst in association.

I accept that the Department of Correctives Services has, as far as is practicable in these circumstances, moved to address the recommendations arising from the review of the operations of Maximum Security Units in order to make them a safer.

Under the circumstances, I am satisfied that the Department of Corrective Services has moved to address the issues and recommendations arising from internal investigation undertaken by the independent inspectors. Accordingly, I do not propose to make any further recommendations concerning this matter.

By virtue of Section 30A(2) of the *Coroners Act 1958*, I make an order prohibiting the publication of information contained in the following exhibits on the basis that they contain information which if publicly available could compromise the safety and/or security of the prison:

Exhibit 2
Exhibit 3 – Attachments numbered 3.2 and 3.3.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
19 December 2006