OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Roy Barnes
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FILE NO(s):	0805/08(4)
DELIVERED ON:	17 March 2010
DELIVERED AT:	Southport
HEARING DATE(s):	15, 16, 17 March 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners Inquest, death in custody, natural causes, drug withdrawal symptoms

REPRESENTATION:

Counsel Assisting:	Mr Mark Plunkett; Mr Peter Johns
Queensland Health:	Mr Kevin Parrott, Crown Law
Queensland Police Service:	Ms Melanie Dixon
Constable Tamara Clucas, Sgt Shaun Groufsky	
& Senior Sergeant Gregory Brake:	Mr Adrian Braithwaite, Gilshenan & Luton

The *Coroners Act 2003* provides in s. 45 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 organizations 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 Roy Barnes. 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

Shortly after mid-night on 6 February 2008, Gold Coast police found 47 year old Mr Roy Barnes with another man at the Currumbin Industrial Estate in possession of a radio scanner and a glass cutting instrument. Mr Barnes was arrested and taken into custody for being in possession of an instrument of house breaking tools at night.

He was refused bail by the watch house keeper and was held in the Southport watch house. He was also denied bail when he appeared in court later that day and so remained in the watch house.

On the morning of Friday 8 February 2008 he was found in a semi conscious state in his cell.

An ambulance was immediately called and Mr Barnes was taken to the Gold Coast Hospital in Southport where he was diagnosed as suffering from a ruptured blood vessel in his brain. Medical practitioners determined his condition was inoperable and Mr Barnes was moved to the palliative care unit where he died at 6:40am on 12 February 2008.

Because the incident was a "death in custody" within the terms of the Act it was reported to the State Coroner for investigation and inquest.[1]

These findings

- confirm the identity of the deceased, the time, place, circumstances and medical cause of his death;
- consider whether the actions or inactions of any person contributed to his death;
- examine the actions of the Southport watch house staff before and after Mr Barnes collapsed;
- consider whether the medical treatment afforded to him while in custody was reasonable and adequate; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances

[1] s. 8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody

or otherwise contribute to public health and safety or the administration of justice.

The investigation

About 1:00pm on Friday 8 February 2008, 45 minutes after the ambulance took Mr Barnes to hospital and upon learning the seriousness of the medical condition; the officer in charge of the watch house Senior Sergeant Graham secured the cell, made inquiries of the other prisoners, and copied segments of the watch house surveillance videos.

At approximately 1:30pm on 8 February 2008, the Internal Investigation Branch of Ethical Standards Command of the Queensland Police Service (QPS) was advised of Mr Barnes' medical removal from the Southport watch house to the Gold Coast Hospital.

The State Coroner's Office notified the Internal Investigation Branch of the Ethical Standards Command that in the event of death, the matter would be regarded as a death in custody.

At 3:00pm on 8 February 2008 an investigator from the Internal Investigation Branch of Ethical Standards Command attended the watch house and found the scene had been secured.

There were no obvious signs of blood or any other stains evident. Bedding, clothing and toilet paper were located. Senior Constable Craig Nelson of the Gold Coast Scenes of Crime Office attended and photographed the exercise yard, cell and items of property.

The investigation was conducted by Inspector D C Kolb of the Internal Investigation Branch of Ethical Standards Command who prepared a comprehensive report into the death of Mr Barnes.

Mr Barnes' body was accompanied by a police officer to the John Tonge Centre, Queensland Health Scientific Services and an autopsy examination was conducted on the morning of 13 February 2008.

Inspector Kolb interviewed other prisoners present at the time of Mr Barnes' collapse, the police officers at the Southport watch house and the pathologists.

I find that the investigation into this matter was professionally and thoroughly conducted and that all relevant records have been accessed. I thank Inspector Kolb for his assistance.

The inquest

A pre inquest conference was held in Brisbane on 19 January 2010. Mr Johns was appointed as counsel to assist me. Leave to appear was granted to the Department of Health, and the QPS. The inquest was held at Southport on 15, 16, and 17 March 2010 at Southport. On that occasion, Mr Plunkett

was appointed as counsel to assist me. Mr Barnes' wife was advised of the inquest and attended but she chose not to seek leave to appear.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered. The evidence was reviewed and submissions were made to the court by counsel assisting and those with leave to appear.

The evidence

I turn now to the evidence. Of course, I cannot even summarize 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 background

Mr Barnes was born in Darlinghurst, Sydney, on 14 July 1960 into a family of five boys.

He was married and lived with his wife of 19 years, Vivienne Lynn Barnes, with whom he had two male children. They were 15 and 17 years old at the time of their father's death

Since the 1980s the family was resident on the Gold Coast.

Mr Barnes had been casually employed on computer work having undertaken tertiary education through distant learning, studying towards obtaining a Bachelor of Social Sciences degree.

At the time of his death he was unemployed and lived with his wife and children at Mermaid Beach on the Gold Coast.

He had a long history of illicit drug use from his early 20s and was hepatitis C positive as a result.

His criminal history was quite extensive. It commenced when he was 25 years of age when he was convicted for drink driving. Thereafter he was convicted of imposition, stealing, breaking and entering of dwelling houses at night time, receiving, false pretences, possession of property suspected of being stolen, fraud, and supplying dangerous drugs.

In 1993 when he was 33 years of age he was sentenced to 7 years imprisonment for breaking and entering of a dwelling house at night time.

Apparently, imprisonment was no deterrent to his offending behaviour because in 2001, when 41 years of age, he again was apprehended for house breaking. On this occasion he was placed on an intensive drug rehabilitation order. But two years later in April 2003 he was caught house breaking again and sentenced to 6 years imprisonment with an eligibility to be considered for parole from 2 February 2006.

Recent medical history

Mr Barnes was a heroin addict. The exact extent of heroin use is unknown, but it is thought that prior to his death his use was about 0.5 to 1.00gm per day.

By 2001, he was diagnosed with hepatitis C. In 2002 he suffered from mild hypercholesterolaemie. In 2003 he had a solar keratosis on his left hand. Earlier in his life he was involved in a motor vehicle accident and suffered multiple trauma injuries.

Not only was he a heroin user but he also suffered from alcohol abuse.

Dr Kevin Chiu of the Mermaid Central Medicare Clinic was Mr Barnes' medical practitioner and saw him most recently on 25 January 2008. Dr Chui stated that Mr Barnes did not complain of any illnesses apart from an upper respiratory tract infection for which he prescribed medication. Dr Chui did not think that there was anything remarkable about Mr Barnes health and was unaware of anything that may have contributed to his death.

Mrs Barnes said he did not complain of any particular illnesses and considered him to have been in good health up until his death. She stated that she was unaware of the extent of heroin use around the time of his death.

Mr Barnes is in custody

The circumstances of Mr Barnes coming into custody were part of a familiar pattern of his offending.

In response to recent break and enter offences in industrial areas on the Gold Coast, Constable Rodney Alan Quinn and Constable Scott Ewington of Coolangatta Police were tasked to patrol likely areas. Shortly after midnight on Wednesday 6 February 2008, those officers were patrolling the Currumbin Industrial Estate when they located Mr Barnes and Mr Kevin Francis Morris walking the streets.

When they were searched, police found a suction glass removing device and a radio scanner. While he admitted to ownership of the scanner, Mr Barnes claimed to have found the glass cutter on the side of the road just prior to being intercepted.

The two men were arrested for possessing in the night time without lawful excuse an instrument of housebreaking, namely a glass removing device contrary to s. 425(1)(c) of the *Criminal Code*. They were taken to the Coolangatta Police Station.

Constable Quinn made computer inquiries and found that Mr Barnes had an extensive criminal history, was on parole and subject to an outstanding warrant of apprehension. He prepared an affidavit objecting to bail which was attached to the watch house registry.

Messrs Barnes and Morris were taken to the Southport watch house and lodged there at 3:45am on 6 February 2008. They were processed by Constable Tamara Clucas.

Constable Quinn and Constable Ewington did not observe any health problems or anything to suggest that Mr Barnes may have been ill or on drugs at any time they were with him.

On reception Mr Barnes was asked the standard questions set out in a Health Questionnaire and Observation Checklist. This is done as a risk assessment and includes specific questions about an incoming prisoner's physical and mental health. None of the answers given by Mr Barnes gave any indication of ill-health. He denied having any drug addiction. He was classified as a mainstream prisoner.

Neither Constable Tamara Clucas, nor any of the other police officers who dealt with him, considered Mr Barnes appeared to be suffering from alcohol or drug withdrawal or any other health complaint.

He was put in a module that comprised a number of cells adjoining an exercise yard where he could mingle with other prisoners. In the evening he was locked in a two person cell alone.

Later that day Mr Barnes attended court. Duty Solicitor Michael Maloney appeared for Mr Barnes. He was refused bail and remanded in Southport watch house to appear in court next on 20 February 2008.

No one who had contact with Mr Barnes in court, other than his wife, had any specific recollection of his appearing ill. Mrs Barnes thought he was displaying signs of drug withdrawal.

At 2:00pm on 6 February 2008, Mr Barnes was visited at the watch house by detectives making inquiries about other unsolved break and enter offences. In the corridor next to the exercise yard, the officers attempted to interview him about these offences. However, Mr Barnes exercised his right not to participate in an interview. One of them knew Mr Barnes from two years earlier. She thought he had lost weight. She also thought his complexion was pale and that he was unwell. When she asked him if he was using drugs again, Mr Barnes replied: "Get fucked" and asked to be returned to the cells.

Medical attention at the watch house

At about midday every day a nurse arrives at the watch house to attend to any prisoner who has asked for medical attention or whom the officer in charge thinks needs to be seen.

Nurse McLean, a registered nurse for 33 years and employed by Blue Care Nursing, has provided nursing care to the prisoners at the watch house for four years. Her task is to see the prisoners, make an assessment and report her findings to the Forensic Medical Officer, a doctor employed by Queensland Health and previously referred to as a GMO.

Mr Barnes was obviously aware of the process and asked to see the nurse. He was therefore taken to the clinic room to see Nurse McLean at about 3.00pm. He told her he was suffering heroin withdrawal. He said he was a regular heroin user and had been using "*a quarter of a weight*" daily for about six months. He told her he had last used "*last night*." Nurse McLean performed a standard examination of Mr Barnes included taking his blood pressure and pulse. She also administered an "Objective opiate withdrawal scale" which, as the name suggests, is an instrument to assist assessing whether a person is suffering drug withdrawal symptoms.

Mr Barnes blood pressure was 125 over 75 and his pulse was 88 beats per minute, both of which were within a relatively normal range for a person in the watch house. However 7 of the 13 indicia for drug withdrawal were noted and accordingly the nurse considered he needed medication to control these symptoms.

Mr Barnes did not complain of anything else and Nurse McLean did not notice any injuries or anything else abnormal about Mr Barnes.

As per standard procedure, Nurse MacLean contacted Dr Catherine Lincoln by telephone to report on the nine prisoners she had seen that afternoon. Dr Lincoln assessed Mr Barnes to be in the early to intermediate stage of opiate withdrawal syndrome. As a result she decided to commence Mr Barnes on diazepam at a dose of 10 milligrams three times a day at 8:00am, 2:00pm and 9:00pm. She also prescribed paracetamol three times a day.

She told the inquest she ordered these drugs not be administered until 8.00am the following morning, in accordance with standard procedures designed to ensure prisoners are not given a sedating drug like diazepam when they might already have other sedatives "on board".

Nurse McLean completed a Prisoner Medication Register and Medical Sheet noting the prescribed medication.

Stock medication is kept at the watch house. When medication is prescribed by a doctor, it is dispensed by a nurse into a small container recording the prisoner's name, prescribing doctor, drug and the dosage with a sufficient amount for 48 hours. It is then administered by watch house officers at the times stipulated.

A nurse was scheduled to see Mr Barnes again on the afternoon of 8 February 2008 to see how his withdrawal symptoms were responding to the drugs Dr Lincoln had prescribed.

Co-accused prisoner Mr Morris saw Mr Barnes after he had seen the nurse. Mr Barnes did not complain to him of ill-health or feeling unwell, although Mr Barnes told him he had been "hanging out" for drugs.

Nothing is reported to have been unusual in Mr Barnes' condition in the afternoon on evening of 6 February 2008.

At 8:00am on Thursday 7 February 2008 Mr Barnes was administered the prescribed medicine.

At 9:30am on 7 February 2008, Mr Barnes was again visited by the detectives he had spoken to the day before and told he was to be charged with another break and enter offence.

The medication he was scheduled to be given at 2:00pm on 7 February does not seem to have been administered. I was not able to ascertain why.

Throughout the afternoon various procedures connected with the proceedings being brought against Mr Barnes were undertaken. None of the officers involved noticed anything untoward about him and all say he made no complaints about his health. Similarly, none of the other prisoners in the module where Mr Barnes was housed report noticing any signs of ill health, although one did mention that some time in the afternoon he saw Mr Barnes acting strangely by running his fingers up and down the wall of his cell.

At 9:45pm on 7 February 2008 he was administered the prescribed medicine and was then locked in his cell.

Prisoner inspections

The night crew staffing the watch house was comprised of Sergeant Groufsky, Senior Constable Holliday, Constable Clucas and Constable Beaman. They were relatively busy. Between 9:40am to 6:30am, 17 people were brought in and processed at the watch house.

The watch house prisoner inspection register for the shift in question contains entries purporting to record that 12 physical inspections were made of the prisoners between 11.30pm on 7 February and 8.30am on 8 February. It became apparent during the investigation that some of these entries were fraudulent – an issue I shall return to later. Nevertheless none of the officers or other prisoners report seeing or hearing anything out of the ordinary during the night or morning that could suggest Mr Barnes met with foul play or was denied medical attention.

Mr Barnes collapses

At 6:00am there is a shift change-over of police staffing the Southport watch house. Officers from the day shift wake all prisoners at about 7:00am by turning on the lights and television and unlocking the shower facilities.

After processing some arriving prisoners between 6:30am and 7:00am, Constable Warren Rielly prepared the yards for the prisoners to shower. He entered Yard One and placed towels on the bench located adjacent to the shower and unlocked the shower door. There were eight prisoners in Yard One at the time. However the officer did not check on the prisoners or talk to them when doing this.

At 7:00am, Acting Senior Sergeant Graham commenced work as the officer in charge. At this time there were only three other officers on the ground level, being Sergeant Smith and Constables Wiss and Rielly.

Shortly after 7:00am, the prisoners were given access to the showers. By about 7.45 all the other prisoners had left their cells, showered and settled down in the yard. As Mr Barnes' cell was located at the end of the yard, the reason for his absence was at first not noticed by his fellow prisoners. One prisoner did however see Mr Barnes sitting in his cell. He was naked and sitting upright, slumped against the wall. The prisoner could not see all of him through the glass partition but noticed he was shaking. He did not tell anyone of his observations.

At about 7:45am Sergeant Smith, Senior Constable Wiss and Constable Rielly entered the yard to collect the used towels.

Constable Rielly locked the showers and was heading towards cell number 3 at the far end, right side of the yard where he saw Mr Barnes seated, slumped on the bench next to the cell doorway.

He was naked, looked pale, was sweating profusely and appeared dazed and only semi-conscious. There was redness around his neck. The pupils of his eyes were dilated. Mr Barnes seemed to understand what the officer was saying when he asked the prisoner what was wrong but his answers were not coherent. Constable Rielly thought that Mr Barnes was having some sort of seizure. Constable Rielly alerted Sergeant Smith and the other watch house staff including the officer in charge, Acting Senior Sergeant Graham.

Sergeant Graham went to the yard and ordered the other prisoners to be returned to their cells. She then went to cell 3 and saw Mr Barnes naked sitting on the bench on the left of the cell door way.

He was pale, sweating and having difficulty in communicating, but conscious. His eyes were open and his breathing was audible and abnormal. Senior Constable Wiss asked him his name, to which he responded: "Barnes". It was decided to move him to a secure area where he could be better attended to. The police took him by his arms and dragged him out of the yard to the bulk holding cell number two around the corner from the exercise yard. Constable Rielly recalled Mr Barnes saying his first name "Roy". Constable Rielly recalled Mr Barnes was scratching himself on the face and body.

Sergeant Graham ordered Constable Gorman to call the ambulance immediately. She went to the Medical Room and saw one of the nurses was fortuitously there. She agreed to see the prisoner immediately.

Nurse Helen Gullison has been a registered nurse for 30 years and is employed by Blue Care. She was by chance at the watch house at that time of day because she was collecting a mobile telephone left there by another nurse when she was asked by Sergeant Graham to see Mr Barnes.

Nurse Gullison obtained the nursing notes on Mr Barnes, and a blood sugar level and blood pressure measuring instruments. She then went to where Barnes was secured. She saw him lying on the floor obviously unwell.

Nurse Gullison checked blood pressure, pulse and blood sugar levels. His blood pressure was 170/110, pulse about 90 beats per minute and blood sugar levels were in an acceptable range. As Nurse Gullison tried to prick his finger to measure his blood sugar levels, Mr Barnes at first pulled his hand away but relaxed when assured they were trying to help him.

His eyes were open, but vacant in appearance. The pupils reacted to light. Mr Barnes was moving his legs and his arm when she applied the blood pressure cup. She thought he was conscious, but in a trance. He ceased responding to attempts to get him to speak. In order to comfort him, Nurse Gullison put a pillow under his head, a blanket over him and waited with him for the ambulance.

At about 8:06am the Queensland Ambulance Service arrived. The ambulance officers found Mr Barnes lying supine, shivering with tremor and unconscious. An examination revealed he was unresponsive, breathing with a palpable pulse. His blood pressure at 8:15am was 160/110 and at 8:17am was 207/125.

Mr Barnes was taken by the Queensland Ambulance Service to the Gold Coast hospital.

At 8:30am Mr Barnes arrived at the hospital where he was examined by Dr Adam McLeavy who did not observe any sign of trauma or injury.

The differential diagnosis made at admission was intra-cerebral haemorrhage secondary to hypertension with drug (heroin) withdrawal. Accordingly, a CT scan of Mr Barnes' head was conducted which revealed a large right front temporal intra-cerebral bleed in the region of the right basal ganglia and internal capsule neck measuring 6.5cm in the anteroposterior, 4cm in transverse and 3.6cm in the cranial caudal diameter.

He had a very low level of consciousness. A review of his condition by a specialist neurosurgeon concluded the brain haemorrhage was inoperable and that the fatal condition was unsalvageable with extremely poor prognosis.

The hospital notes record that the diagnosis and the likely fatal outcome were explained to Mrs Barnes' wife. It was agreed that Mr Barnes should be extubated and that he was only suitable for palliative care.

Throughout Saturday 9 February 2008 Mr Barnes remained unconscious and was again assessed as being in a fatal unsalvageable condition. A CT scan showed signs of brainstem compression.

On Sunday 10 February his condition remained unchanged. On 11 February Mr Barnes remained deeply unconscious and was transferred to the palliative care unit at the Pacific Private Hospital.

At 6:20am on Tuesday 12 February Mr Barnes died. Late the same day Mr Samuel Barnes, Roy's brother identified his body to Senior Constable Marks.

Autopsy results

On 12 February 2008 I ordered that a full internal and external autopsy be performed on Mr Barnes' body. This was carried out the next day by Dr Alex Olumbe together with Dr Anthony Joseph Ansford, both of whom are experienced forensic pathologists.

Inspector David Kolb, Sergeant Wayne Roberts and Constable Carolyn McKinlay were present as observers. Photographs were taken by Sergeant Roberts.

On the skin the pathologists noticed old needle track marks in the anterolateral aspect of the left forearm. Histological examination of multiple sections from the left forearm confirmed the presence of old needle track marks including chronic inflammation in the subcutis, giant cells, granuloma formation and numerous siderophages. There was chronic vasculitis and a recent thrombus in a vessel.

The pathologists did not find any injury to the scalp, skull or neck. Upon internal examination no fracture to the skull was found. There were no signs or any indication of any trauma or violence at all being inflicted on the body of Mr Barnes.

Most strikingly was a massive intra-cerebral haemorrhage involving the right hemisphere centred on the basal ganglia. The presence of intra-cerebral haemorrhage was markedly obvious with the right basal ganglia totally replaced by the haemorrhage. The parenchyma was markedly swollen, gyri crests were flattened and suici obliterated.

An examination of the heart revealed that the coronary arteries had moderate to severe non-calcific atheroma with 70 per cent luminal narrowing. Multiple sections, the left anterior descending coronary artery and right coronary artery confirmed the presence of significant atheroma. There was a fresh and acute haemorrhage in the atheromatous plaque of the right coronary artery.

They observed the liver had a distorted architecture caused by chronic hepatitis C infection.

The whole brain was submitted to two specialist neuropathologists for closer examination. Dr T E Robertson and Dr A E G Tannenberg prepared a Neuropathology Report and Dr A E G Tannenberg prepared a Macroscopic Report of an examination of the brain.

The cerebral hemispheres of the brain were serially sectioned in the coronal plane. This gave closer detail to the massive intra-cerebral haemorrhage which involved the right hemisphere and was centred on the basal ganglia.

The pathologists concluded that there was no injury which might have contributed to his death.

Toxicology tests of samples of blood and urine taken at the hospital prior to death showed only the presence of therapeutic levels of diazepam and its metabolites which the pathologist found were non-contributory to the death. Heroin was not detected, although as it has a half life of only three or four hours this is not surprising.

The pathologists considered the presence of significant coronary atherosclerosis also might have contributed to his death.

The pathologists concluded that the presence of intra-cerebral haemorrhage might be attributed to withdrawal symptoms which include high heart rate and possibly transient high blood pressure, which could have led to the adverse/fatal effect in a setting of severe coronary atherosclerosis.

No doubt the coronary atherosclerosis was contributed to by Mr Barnes being a smoker. The pathologist on external examination noted an intense yellowish brown nicotine staining on the right index and middle fingers. The outer surface of the lungs showed moderate black geographical pigmentation and coalescing haemorrhagic areas on the diaphragmatic surfaces of the lower lobes. Histological examination of the lungs showed confluent and diffuse bronchopneumonia. Severe emphysema and numerous clumps of tobacco macrophages were noted.

In the result the pathologists concluded that after considering the circumstances of death, reviewing of the medical charts, examining the neuropathologist reports and being informed by toxicology reports and their own examination of the deceased, the cause of death was intra-cerebral haemorrhage with contributory factors of coronary atherosclerosis and chronic intravenous drug use.

Conclusions as to the circumstances of death

From the time that he came into custody just after mid-night on 6 February 2008 until the morning of 8 February, Mr Barnes was routinely seen by watch house police staff, investigating police, fellow prisoners, court staff, defence lawyers, prosecuting police, members of the public in court, the nurse, and other prisoners. During that time he did not complain or give any indication of a worsening medical condition other than those usually associated with drug withdrawal, which he reported to Nurse McLean. In the hours before his collapse he apparently made no other effort to seek assistance by using the intercom button within his cell to call for help.

During the 55 hours Mr Barnes was in custody there was no indication he may be about to suffer from an underlying medical condition that would render him unconscious. There is no evidence indicating any foul play or violence played any part in the death. He was adequately cared for during his incarceration in that the only time he raised a health concern with the staff of the watch house it was responded to by his seeing a nurse.

Although there was non compliance with aspects of watch house policy concerning prisoner inspections which I shall deal with later, any failings in that regard in no way contributed to Mr Barnes' death. The video monitor in his cell shows that at 7.12am on 8 February he was walking around his cell. A short time later, at 7.48am, he was found semi comatose. The medical evidence is that by that time nothing could have been done to save him.

The apparent failure of watch house staff to provide Mr Barnes with the second scheduled dose of diazepam at 2.00pm as prescribed has not been explained and is of concern but there is no evidence that it contributed to his death.

I am persuaded Mr Barnes died from natural causes and that no other person played any part in his death. There is a basis for concern about aspects of the management of his heroin withdrawal that I shall deal with later. In contrast to alcohol withdrawal, where complications can be life threatening, death from untreated opioid withdrawal is rare, unless against the background of some other co-existing pathology.

Dr Hayllar, an expert whose credentials I shall detail later, said in a report prepared for the court:

> *The co-existing pathology disclosed at Mr Barnes' post mortem appears to have been sufficient to lead to a fatal complication in combination with opioid withdrawal. While more intensive management of withdrawal does not eliminate symptoms entirely, it largely prevents the autonomic effects which contribute to raised pulse and blood pressure, thus more aggressive management of his withdrawal might have avoided this fatal complication.*

Mr Barnes was suffering from moderate to severe coronary artery disease, hepatitis C, chronic heroin abuse and the effects of prolonged and heavy smoking. The added stress of heroin withdrawal may have been sufficient to lead to his death from intra-cerebral hemorrhage.

A more intensive management of the withdrawal may have reduced the withdrawal effects but as I can not be satisfied to the requisite standard that those effects precipitated the hemorrhage, I could not reasonably find any such shortcomings, if they occurred, caused or contributed to the death.

The response of the officers who found Mr Barnes in a semi conscious state was timely and appropriate.

Findings required by s45

I am required to find, as far as is possible, who the deceased person was, the circumstances of his death and when, where and by what means he came by his death. As a result of considering all of the material contained in the exhibits, and the oral evidence I am able to make the following findings:-

Identity of the deceased –	The deceased person was Roy Barnes.
How he died –	Mr Barnes died form natural causes that became acute while he was undergoing heroin withdrawal in a police watch house.
Place of death –	He died at the Pacific Private Hospital on the Gold Coast.
Date of death –	He died on 12 February 2008.
Cause of death –	Mr Barnes died from a spontaneous intra-cerebral haemorrhage while suffering from heroin withdrawal and the effects of coronary atherosclerosis, hepatitis C, and chronic intravenous drug use.

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.

I have found that Mr Barnes died suddenly of natural causes and that the response to his collapse was timely and appropriate. However there are aspects of the operation of the Southport watch house at the relevant time that require comment, but first some detail about the watch house and its client population.

The Southport watch house which had operated since 1998 is considered to be a large watch house (Category A facility). It is the second busiest watch house in Queensland. In 2001, 9750 prisoners were processed there. By 2008, the intake had increased to 15,000 prisoners and this year it is expected prisoner numbers will top 16,000.

In February 2008, the Southport watch house was staffed by 32 police officers, which included 1 Acting Senior Sergeant, 6 Sergeants, 2 Acting Sergeants, 23 Senior Constables and other constables seconded from the Southport Police Station. There are now 40 full time staff and a pending application to add further to that complement.

The complex is comprised of 28 cells, 5 segregation cells, 3 large segregation cells, 1 high visibility cell, I drunk's tank, 1 holding cell and 3 padded cells with bedding for 66 prisoners consisting of 37 on ground level and 29 on level 1. Each standard cell can accommodate 2 prisoners which are accessed via a shared communal exercise yard and shower facility. The Southport watch house can accommodate 65 prisoners over extended periods if necessary.

There are 170 cameras installed in and around the watch house complex of which 80 cameras make recordings, but only at the rate of 16 frames per minute (every seven seconds). There is also an intercom button in the cells which activates an alarm in the monitoring room which is audible at the charge counter.

It is in that context that the circumstances of this case raise four issues that may warrant comment from a prevention perspective. They are:-

- The inspection of watch house prisoners;
- The quality of electronic monitoring equipment in the watch house;
- The provision of nursing care to watch house prisoners; and
- The management of heroin withdrawal in watch house prisoners

Inspection of prisoners

The Operational Procedures Manual (OPM) requires watch house managers to ensure that inspections are conducted regularly at varying intervals which should be no greater than one hour – section 16.9.5 and section 16.13.3.

That second section also states that staff inspecting prisoners are to:

- read the information in the watch house Custody Register;
- observe the prisoner's physical appearance and demeanour;
- ask prisoners who are awake if they are well;
- pay particular attention to any prisoner apparently intoxicated to ensure that intoxication is not masking symptoms of a serious medical condition;
- ensure that a sleeping prisoner is breathing comfortably and appears well;
- wake a sleeping prisoner when the officer is unsure or is concerned about conditions of that prisoner; and
- ensure security of the cell keys.

Obviously those observations can not be undertaken if the prisoners are only viewed over video monitors. This is explicitly confirmed by the order that "*Prisoner inspections are to be conducted personally irrespective of whether or not video monitoring equipment is installed."*

It is also the policy that officers in charge of regions are to ensure that prisoners in watch houses are inspected where practicable by a police officer other than a police officer involved in the administration of the watch house at least 3 times in every 24 hours. It is suggested this be done by a regional duty officer (RDO) or a district duty officer (DDO) both of whom will usually be senior to the watch house keeper.

These policies are further operationalised by the Southport watch house Standard Operating Procedures (SOPs) which require a physical inspection of all prisoners half past the hour every hour, the details of which are required to

be recorded in the Prisoner Inspection Register. These inspections are to be conducted each half hour after inspections on video surveillance cameras. This is to ensure prisoners are not suffering from drug withdrawal, mental illness or assault from other prisoners who may need segregation from mainstream prisoners for their safety.

Inspector Kolb reported disturbing issues with the performance of inspections. His investigations concluded that little or no reliance can be placed on the prisoner inspection register from the commencement of the shift at 10:00pm on 7 February 2008. The evidence heard at the inquest confirmed this conclusion.

Constable Clucas said in evidence that when told at about 2.35am that the DDO had arrived, she knew he would look at the Prisoner Inspection Register and so, in accordance with what she had been told to do by other more senior watch house staff, she checked to see if it was up to date. She found no entries had been made since 00.30 hours. She then made false entries indicating physical checks had been made every half hour at 1.00, 1.30, 2.00 and 2.30 when she had no basis for believing this was true. The physical inspections recorded by Senior Constable Nelson as having been undertaken at 4.07, 5.09 and 5.58 were video checks only. The record for 04:07am is obviously out of sequence with the preceding entry by the RDO at 04:40am.

It was established that the DDO and the RDO also only undertook video checks rather than physically inspecting the prisoners as required by the OPM. They could give no convincing explanation for their failures to do what was required.

The reason for this non compliance is difficult to ascertain with precision. Certainly I detected no lack of commitment from the watch house staff involved. On the contrary, the Acting Officer in Charge and the shift supervisors who gave evidence impressed as thoughtful and dedicated officers concerned to ensure the watch house was professionally managed.

It is trite to say that this has been a chronic problem. As long ago as 1989, the dangers of the failure to adequately inspect watch house prisoners has been drawn to the attention of the QPS by the Royal Commission into Aboriginal Deaths in Custody.

Commissioner Lew Wyvill QC in his *Report of the Inquiry into the Death of John Raymond Pilot, 1989*, when attempting to explain why the watch house prisoner had not been adequately inspected observed;

> *"I have also been critical of practices that have developed for whatever reasons: habit, the example of seniors and others, understaffing, lack of training, failure to understand the purpose of a procedure etc."*

In that death in custody there was no check of any prisoners or even a visit to the level of the Brisbane watch house between the hours of 4:30am and 6:00am. Mr Pilot died of an alcohol withdrawal seizure between 4:40am and 5:00am. The Royal Commissioner recommended that "*No prisoner should be*

isolated from his jailers that neither he nor those nearby can summons assistance."

The *National Report of the Royal Commission into Aboriginal Deaths in Custody 1991* by Commissioner Elliot Johnson QC recommended that:

> *"Police instructions and training should require that regular, careful and thorough checks of all detainees in police custody be made."(*par 137(a))

Volume 1 of the *National Report of the Royal Commission into Aboriginal Deaths in Custody 1991* commented adversely on *"the considerable slackness in relation to checking."* (par 3.3.30) Commissioner Johnson QC continued:

> *"Many officers said quite frankly that their checks on various occasions were nothing more than head counts. There were cases of checks being recorded on the hour whether performed on the hour or not (and sometimes, I suspect, whether performed or not). The entries were standardized – not in itself surprising but so much so that plainly these entries were not a very accurate account of reality."* (par 3.3.30)

The similarity between the causes of dilatory inspections identified by Commissioner Wyvill and the officers involved in this matter is striking. Constable Clucas advised she had received no training in her obligations as a member of the watch house staff, the acting officer in charge and others blamed the high work load, and the casual approach of the senior officers meant to independently oversee the inspection process was redolent of habitually poor practice. It is disappointing that so many similarities remain after so long when so much else about policing has improved.

Since this death, the Assistant Commissioner South Eastern Region has addressed these failures.

- Disciplinary action was taken against three officers.

- The obligations contained in the OPM and the SOPs have been re enforced with all staff in the region who have been warned any breaches will result in managerial guidance and persistent failures will lead to disciplinary action or removal from the work environment.

- Guidelines for the RDO state that where possible the RDO is to visit the Southport and Beenleigh watch houses at least once each afternoon and night shift during the week and all shifts over the weekend. The DDO manual requires the DDO to visit the Southport watch house each shift.

- A "dead man" alarm was installed in the Control Room which activates with a blue strobe and audible alarm every 30 minutes. A code is then required to turn off the alarm. The purpose of this alarm is to ensure officers performing duties in the watch house are reminded to complete a prisoner check every 30 minutes.

These responses seem appropriate. The only other related issue raised during the hearing concerned the position of the alarm switching. It was suggested that if it were moved to the end of the corridor in which some of the cells are situated, the temptation to deactivate the alarm with the intention of doing the inspection later, could be minimised. I have insufficient evidence on which to base an opinion as to the appropriate placement of the switch but having regard to the frequency with which this was raised by officers working in the watch house I am persuaded the matter deserves some attention.

Recommendation 1 - Review of location of dead man switch

I recommend the position of the dead man switch in the Southport watch house be reviewed to ensure its placement is most conducive to compliance with the obligation to inspect prisoners.

Upgrading of video equipment

The video surveillance system at the time at the Southport watch house consisted of 170 cameras of which 60 cameras made recordings, but only at the rate of 16 frames per minute (every seven seconds). The images recorded were of poor quality and as Inspector Kolb reported they "*could only be described as barely adequate*". In October 2008 the Close Circuit Television (CCTV) recording system at the Southport watch house was upgraded to a digital network (MPEG-4) recording system and analogue switching system which automatically sequences images from each cell to appear on monitors. Funding has been approved to upgrade the switching system from analogue to digital to be completed from July 2010. The improvement will result in images at the rate of 5 per second.

I consider this an appropriate response and no further comment from me is necessary.

Nursing care in the watch house

A nurse employed by an agency that contracts with the QPS visits the Southport watch house daily. He or she sees prisoners who have asked to be seen or identified by the staff as needing attention. When those prisoners have been attended to the nurse leaves and attends to other tasks allocated by the employing agency.

This raises two potential problems: the nurse may be anxious to get onto the next assignment and therefore pay less attention to the needs of the prisoners than is desirable; and, after the nurse leaves, watch house staff must either phone the on-call doctor or arrange for a prisoner possibly in need of attention to be transported to hospital. I heard no evidence indicating the on call doctor was not willing to provide this service but telephone medical advice about a patient who has not been seen by a doctor or para medic is fraught. Prisoners taken to hospital require two police escorts, taking a scarce and valuable resource "off the road."

As already mentioned, it is anticipated 16,000 prisoners will pass through the Southport watch house this year. Well qualified witnesses estimated 80 – 90%

will be acutely or chronically affected by drug or alcohol abuse. The prisoner population has numerous other well recognised elevated health risks – mental illness and infectious diseases to mention only two. I below refer to the need for a review of the drug withdrawal regime that is also likely to impact upon the nursing needs of the watch house.

Recommendation 2 – Nursing needs review

In conjunction with the review of the regime for managing drug withdrawal in watch house prisoners, I recommend the nursing needs of the Brisbane and Southport watch houses be reviewed and that the review take into account the police time that could be saved by not having to escort prisoners to hospital for assessment.

Managing drug withdrawal

The inquest was greatly assisted by the evidence of Dr Jeremy Hayllar, the Clinical Director of the Alcohol and Drug Service, Metro North Health Service District, Queensland Health, since 2004. Dr Hayllar has extensive practical experience in managing drug withdrawal by persons addicted to various illicit drugs and a deep understanding of the research literature relevant to the challenges this presents.

He advised the court that reliable survey data enables him to conclude that 13% of watch house detainees are likely to have used heroin in the two or three days prior to their incarceration. This extrapolates to 2080 prisoners per annum if, as anticipated, 16,000 people pass through the Southport watch house this year.[2] Clearly then, managing heroin withdrawal is a challenge the staff there will frequently be required to deal with.

Withdrawal symptoms occur in stages, depending upon the time of the last dose and the half-life of the opioid used.[3] For a short-acting opioid, such as heroin, the typical withdrawal course is:

- Three to four hours after last dose — Drug craving, anxiety, fear of withdrawal;
- 8 to 14 hours after last dose — Anxiety, restlessness, insomnia, yawning, rhinorrhea, lacrimation, diaphoresis, stomach cramps, and mydriasis
- One to three days after last dose — Tremor, muscle spasms, vomiting, diarrhoea, hypertension, tachycardia, fever, chills, and piloerection.[4]

The short elimination half-life of heroin results in a particularly acute and intense withdrawal syndrome although it is rarely fatal compared say, to

[2] Obviously the majority will not be detained for a sufficient period for withdrawal symptoms to manifest but 13% of those who are detained will be at risk.
[3] Michael F Weaver, MD; John A Hopper, MD, *Opioid withdrawal management during treatment for addiction*, March 30, 2009
[4] Kosten, TR, O'Connor, PG. Management of drug and alcohol withdrawal. N Engl J Med 2003; 348:1786

alcohol withdrawal.[5]

Opioid withdrawal is characterized by mydriasis (pupillary dilation), yawning, increased bowel sounds, and piloerection. If the patient is in severe distress, heart rate, blood pressure, and respiratory rate may be increased. Hypotension may be present in the setting of volume depletion from vomiting and diarrhoea.[6]

A young patient may tolerate a heart rate of 120, whereas an older person with coronary artery disease should not be allowed to remain hypertensive and tachycardic for any prolonged period.[7]

Having regard to these facts it is easy to understand why Mr Barnes was placed at risk of suffering from severe effects of heroin withdrawal.

Dr Lincoln considers she was following an appropriate clinical protocol when she prescribed diazepam, 10mg and paracetamol 1gm both three times per day. In accordance, it seems, with standard practice within the watch house, the administering of these drugs was delayed until 6.00am on 7 February. Dr Hellyar was critical of this for a number of reasons:

> *"The dose of diazepam prescribed for Mr Barnes (diazepam 10mg three times daily, of which only 2 doses not 3 were given) was lower that that recommended in the current Queensland protocols (diazepam 10mg four times daily for the first 3 days). In addition the delay in administering the treatment (until ~35 hours after his last use of heroin) was inappropriate."*

Counsel for Dr Lincoln submitted she was entitled to exercise clinical judgment to prescribe less diazepam than 40mg daily. However, according to Dr Hallyar this was a "*standard dose*" and in more severe cases, the current protocol authorised the giving of more drug. The protocol says "*Diazepam is given at a dose of 10mg every six hours for three days..."* [8]

Although Dr Lincoln professed to be prescribing in accordance with that protocol, in fact she was obliged to diverge from it significantly. As Dr Hallyar agrees, administering the other drug recommended to be used in concert with diazepam, clonidine, is not appropriate in a custodial setting where its effect can not be closely monitored. I do not mean to be critical of Dr Lincoln. I accept she was doing her best in a complicated field where good guidance is scarce.

New South Wales has adopted *Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW, 4 July 2008* (the NSW guidelines). The NSW guidelines

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[5] The British Psychological Society and The Royal College of Psychiatrists, *DRUG MISUSE, Opioid detoxification National Clinical Practice Guideline Number 52* National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence, 2008, p 79

[6] Andrew Stolbach, MD, Robert S Hoffman, MD, *Opioid withdrawal in the emergency setting*, September 30, 2009 at 4

[7] Ibid

[8] Clinical protocols for detoxification in hospitals and detoxification facilities, 6 - 19

provide up to date knowledge and current level of best practice for the treatment of withdrawal, also called detoxification, from alcohol and other drugs such as benzodiazepines, heroin and other opioids, cannabis, and psychostimulants. The key concept of the NSW guidelines in the management of withdrawal is patient safety.

Although the NSW guidelines note people in custody may have special needs, the aim of the NSW guidelines is to assist three broad groups of clinicians to manage drug-dependent people experiencing withdrawal, namely, specialist withdrawal services, hospitals, nursing homes, and other acute facilities that admit patients, primary care clinicians such as general practitioners, non-government agencies and community and welfare services. None of which are apposite to a watch house setting.

As a result of reading Dr Hallyar's report and receiving his oral evidence I am persuaded there are currently no clinical guidelines or protocols that adequately give guidance as to how heroin withdrawal should be managed in a watch house. There seems little doubt that there are other pharmacotherapies superior to diazepam, although there is no easy and obvious answer to all of the challenges raised by the context on which we are focused.

As noted above, Dr Hallyar is also critical of the so called "24 hour rule". He points out that there is no need to delay giving drugs to manage heroin withdrawal symptoms on the basis that the prisoner may still be under the influence of opioids taken before incarceration, because if that were the case, he or she would not exhibit the symptoms of heroin withdrawal and the diazepam would not be indicated or given. He went on to say he could think of no circumstances where the administering of drugs for which there appeared a clinical need would be contra indicated because of uncertainty of pre imprisonment ingestion.

It was submitted that the "24 hour rule" was not in fact as inflexible as that terminology might suggest. I am not so sure. In this case, Mr Barnes received no medication until he had been in custody for 32 hours, and then an inadequate dose – too little, too late.

Recommendation 3 – Watch house heroin withdrawal guidelines

I recommend that Queensland Health collaborate with the Queensland Police Service to develop guidelines to assist doctors to manage prisoners suffering from heroin withdrawal. In view of the large and growing number of prisoners at risk and the significant uncertainty concerning the suitability of the guidelines currently being used, this should be done as a matter of urgency.

Recommendation 4 – Review of the "24 hour rule"

In view of the serious doubts raised by Dr Hallyar as to the advisability of refraining from administering medication to watch house prisoners for 24 hours after a doctor has prescribed it, I recommend that the practice be reviewed.

I close the Inquest.

Michael Barnes
State Coroner
Southport
17 March 2010