OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leon Mark CARROLL**
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JURISDICTION:	Brisbane
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FINDINGS OF:	Mr Michael Barnes, State Coroner
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REPRESENTATION:

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Department of Corrective Services:	Ms Kay Philipson

Findings of the Inquest into the death of Leon Mark Carroll

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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 organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Corrective Services. These are my finding in relation to the death of Leon Mark Carroll. They will be distributed in accordance with the requirements of the Act and a copy will be posted on the website of the Office of the State Coroner.

Introduction

On the morning of 1 December 2003 Mr Carroll was found by correctional staff to be hanging in the cell he alone occupied at the Arthur Gorrie Correctional Centre. He was immediately cut down and first aid was provided. He did not have a pulse and was not breathing. He was not able to be resuscitated and was pronounced dead at the scene.

These findings determine how the death occurred and whether any other person was directly involved in it. They also consider whether any changes to prison policy or practice could have prevented the death.

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

Because Mr Carroll, was when he died, detained in a corrective services facility, his death was a "*death in custody*" within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.

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. If possible he/she is required to find:-

1 whether a death in fact happened
2 the identity of the deceased;
3 when, where and how the death occurred; and
4 what caused the person to die.

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.*

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. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

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.

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. 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.

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially. 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* 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.

The investigation

I will now say something about the investigation of Mr Carroll's death. As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or the authorities have failed in their duty to properly care for the prisoner. It is therefore essential that even when a death appears at the outset not to be suspicious, the investigation is thorough and rigorous. I am satisfied that it was in this case.

As soon as the ambulance officers who attended at the correctional centre to try

and revive Mr Carroll advised prison staff that they had been unsuccessful and that the prisoner was dead, police were called and scene was secured. Uniform police from Mt Ommaney station attended and maintained the integrity of the crime scene until detectives from the Corrective Services Investigation Unit (CSIU), a specialist group from the Queensland Police Service (QPS) who undertake the investigation of all deaths and serious incidents in correctional centres, arrived at about 8.30am.

The scene was photographed. Relevant evidence within Mr Carroll's cell was photographed and secured. Witnesses were interviewed and statements obtained. A handwriting expert identified the handwriting on a suicide note as that of Mr Carroll.

On 2 December 2003 an autopsy was conducted by Dr Beng Ong a forensic pathologist from the John Tonge Centre. On the next day the body was identified as that of Mark Leon Carroll by his wife.

The CSIU investigation report was received by the Office of the State Coroner in 1 July 2004. Since then, further enquiries have been undertaken in relation to the management of prisoners with a history of self harm and/or suicidal ideation and the elimination of hanging points.

The inquest

A pre-hearing conference was held in Brisbane on 16 of March 2006. Mr Eberhardt was appointed Counsel Assisting. Leave to appear was granted to The GEO Group Australia Pty Ltd – the operators of the Arthur Gorrie Correctional Centre and the Department of Corrective Services. Mr Carroll's family was not represented but his wife liaised with counsel assisting before and during the inquest. A list of witnesses was settled and the issues to be examined during the inquest were agreed upon. The inquest then proceeded over two days on 16 and 17 May 2006. The matter was then adjourned to enable an independent psychiatrist report to be received and considered. Seven witnesses gave evidence and eighty one exhibits were tendered.

The evidence

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

Background

I received little evidence in relation to Mr Carroll's early life. The material before me indicates that he served a short term of imprisonment in 1984 the relevance of which is that he would have known of the attitude of prisoners to those charged with child sex offences.

In 1996 Mr Carroll married.

Throughout the marriage difficulties were caused by Mr Carroll's heaving drinking and gambling. The couple separated on a number of occasions. Throughout 2002 and 2003 Mr Carroll's drinking became heavier and this caused more problems within the family as he was frequently aggressive and belligerent when he came home drunk.

In October 2003 he moved out of the family home at Wonglepong into a caravan park at Advancetown. On 1 November 2003 a female relative who was then twelve went to stay at the caravan park with Mr Carroll for the weekend. She took a female teenage friend with her. During the night the friend witnessed Mr Carroll sexually assaulting the relative. The friend telephoned someone to come and collect her from the caravan park and went immediately to police to report what she had seen. The next day the Mr Carroll was charged with raping the female relative on 1 November 2003 and four other sex offences allegedly committed in the preceding months. Mr Carroll came before the Southport Magistrates Court on 4 November 2003 and was remanded in custody.

Initial medical assessment at the Arthur Gorrie Centre

On 4 November 2003 Mr Carroll was transported to the Arthur Gorrie Correctional Centre - a remand and reception facility. As part of the usual initial assessment of his health needs, Mr Carroll was interviewed by a social worker. He told her things that made her believe that he was "*hopeless and helpless*". Although Mr Carroll denied any current suicidal intent the counsellor considered that he was at risk of self harm or suicide. Accordingly, she completed the necessary paper work to cause Mr Carroll to be reviewed by a psychologist. In the meantime the social worker ordered that he be placed on fifteen minute observations and detained in the medical centre where he could be watched.

Also, as part of his initial assessment, Mr Carroll was prescribed diazepam to assist with his alcohol withdrawal symptoms.

On 7 November 2003 Mr Carroll was interviewed by a prison psychologist who had been assigned to conduct an "interim risk plan" assessment. She did not have access to the notes made by the social worker who had ordered the assessment or the prisoner's medical file when she was interviewing Mr Carroll.

The psychologist says that Mr Carroll seemed open and honest with her. He answered all of her questions and expanded when asked open ended questions. She says that his mental status examination did not flag any indicators of risk. His sleep, behaviour and appetite all appeared to be normal and he gave no indication that he was a potential risk. She says that her observations were confirmed by the custodial officers who had been observing Mr Carroll whilst he was in the medical unit. Mr Carroll expressly denied any history of suicide attempts or deliberate self harm, he also denied current ideation, intent or plan of

suicide or deliberate self harm. It was on this basis that the psychologist completed a recommendation that Mr Carroll be taken off observations and returned to the protection unit were he was to be housed as a result of the nature of his charges.

In accordance with procedures governing such matters, later that day she relayed her opinion to the High Risk Assessment Team (HRAT) which was comprised of another psychologist, a doctor and a corrective services operational representative who reported on the observations carried out on Mr Carroll by custodial staff. The counsellor who initially assessed Mr Carroll was also a part in that meeting.

The psychologist's recommendation that Mr Carroll be taken off observations was accepted. None of the participants of the meeting could recall any of the discussion about the case. When giving evidence at the inquest, the psychologist conceded that only a few minutes were devoted to each case that was considered at the HRAT meeting but she contended that if even one member of the team had voiced concerns the recommendation would not have been implemented.

Carroll returns to protection unit

When Mr Carroll was returned to the protection unit, he ceased to be under "official" observation but he was co-incidentally placed in a cell with another prisoner. That prisoners reported that generally Mr Carroll seemed accepting of his circumstances although he recalled on the 16 November 2003, after a legal visit, Mr Carroll made comments which could interpreted as a threat to kill himself.

Mr Carroll asked the other prisoner whether there were items in the cell he could use to kill himself with and said words to the effect "*when they find out what I'm in here for, they will kill me anyway*". The other prisoner told Mr Carroll that if he made anymore remarks like that the prisoner would feel obliged to report them to the authorities. Over the next week or so Mr Carroll seemed settled in himself and had no apparent conflict with any other prisoners. He took steps to recover money that was owing to him from the employment he had been in prior to his incarceration and discussed the possibility of working for his cellmate when they were both released.

On 30 November 2003 Mr Carroll's cellmate was transferred to another unit leaving Mr Carroll the sole occupant of the cell. Another prisoner recalls him expressing pleasure in anticipation of having the cell to himself.

The circumstances of the death

At about 5:50pm on the 30 November 2003 Mr Carroll was locked in his cell as were all other prisoners in the unit. This process was undertaken by two officers who checked and re-checked each cell to ensure that only the allocated prisoners were in them and that the cell doors were locked and secured. One of

those officers specifically recalls seeing Mr Carroll in his cell and says he was alive and well at that time.

Throughout the night a number of head counts were made of the prisoners. Although the officers who undertook those checks say they do not specifically remember seeing Mr Carroll they were satisfied on each occasion that nothing untoward was happening in any of the cells.

The prisoners in the cells surrounding Mr Carroll's also say they heard and saw nothing untoward occurring during the night.

At 6:42am on the 1st December 2003 the officer conducting the morning head count prior to unlocking the cells approached the cell occupied by Mr Carroll. He saw him apparently standing against the wall to the right of the cell door. On closer inspection he saw that Mr Carroll was not moving and his chin was resting on his chest. It was then that he noticed a white piece of cloth around Mr Carroll's neck and saw that it had been fashioned into a ligature the other end of which was tied around bars in the louvre windows above the bunk.

The cell was immediately unlocked and Mr Carroll was cut down. Nurses from the medical wing and Queensland Ambulance were immediately summoned.

It is noticed that Mr Carroll was not breathing, he was unconscious, had fixed, dilated pupils and was cold to the touch. His tongue was wedged between his teeth and his extremities were cyanosed, no pulse or blood pressure could be detected. His body was stiff.

Queensland Ambulance officers arrived at 7:09am and applied a cardiac monitor which confirmed that Mr Carroll was dead. Resuscitation attempts were then abandoned.

The cell was then secured until the arrival of CSIU officers at approximately 8:30am.

It was noticed that Mr Carroll had rolled up towels and clothing on his bed under the blanket fashioned in a manner to make it appear that someone was sleeping in the bed.

A note apparently signed by Mr Carroll, indicating an intention to take his life was found on his desk. Handwriting evidence confirmed that it had most likely to be written by Mr Carroll.

The officer who first unlocked the door was adamant that there was no one else in the cell when he opened it.

The autopsy

The autopsy referred to earlier which was undertaken on the following day

suggested hanging was the most likely cause of death. There were no other injuries to the body which would indicate Mr Carroll had been involved in any struggle or that any third party had participated in his death.

I am consider the evidence establishes that Mr Carroll intentionally ended his own life and that no other person was directly involved in that event. I am also satisfied that those responsible for guarding Mr Carroll on the day of his death had no warning of his intention to commit suicide and that they acted appropriately when he was discovered. I find that he was by then already dead and that there was nothing that those officers could have done to revive him.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Leon Mark Carroll

Place of death – He died in cell C9 at the Arthur Gorrie Correctional Centre, Wacol, Queensland

Date of death – Mr Carroll died on 1 December 2003

Cause of death – He died from self inflicted hanging.

Concerns, comments and recommendations

Section 46, in so far as is it relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety or ways to prevent deaths from happening in similar circumstances in the future. I have found that none of the prison officers or other prisoners caused or contributed to the death and that nothing more could have been done to save Mr Carroll after he was found hanging. There are however two issues which require further consideration. Namely, accuracy of the assessment made of Mr Carroll's risk of self harm and the safety of the cell in which he was incarcerated. I will deal with each of those issues in more detail below.

Risk assessment procedures

As described earlier, when Mr Carroll was interviewed by a social worker on the day he arrived at the Arthur Gorrie Centre, she formed the view that he posed a significant risk of suicide or self harm. As we now know this assessment was accurate. It therefore raises the question of why the processes that followed that initial assessment reversed it and removed protective mechanisms that were put

in place while it remained extant.

The psychologist who chaired the High Risk Assessment Team meeting that made the decision to reverse Mr Carroll's high risk status says that the Team had regard to the information provided by custodial officers who had been assessing him – they indicated his behaviour seemed in the normal range, and the psychologist who had earlier that day interviewed him – she advised that after an extensive interview she could find no basis to conclude that he continued to be at high risk. The medical member of the team informed the meeting that Mr Carroll had successfully undertaken his alcohol addiction withdrawal therapy. Although consideration of Mr Carroll's case was very brief, some five to six minutes, none of those people had any concerns that he continued to pose a threat to himself and he was therefore discharged back into the general protected prisoner population.

When considering whether this flawed decision indicated a problem with the processes by which it was made, I was greatly assisted by the report prepared by Dr Ian Curtis, a clinical and forensic psychiatrist of considerable experience and standing. He expressed the view that it is impossible to provide absolute security for an inmate in a prison but it is possible to engage in risk reduction. He confirmed the obvious that an aspect of such a strategy would be to identify those most at risk as the procedures employed at the Arthur Gorrie Centre attempt to do.

Dr Curtis noted that those who had contact with Mr Carroll in the days leading up to his death noticed nothing abnormal about him and also pointed to the fact that even his suicide note the deceased made a jocular remark. Dr Curtis described this presentation as that of "*a smiling depressive*" and observed that such people "*tend to be very difficult to assess because they have already planed, decided and (in an intrapsychic sense) executed the suicide plan"*. Dr Curtis points out that it is very difficult for a practitioner to get behind the calm relief of a prisoner who has already made up his/her mind to suicide and detect that this is the basis of their apparently normal presentation. For this reason Dr Curtis concludes, in relation to Mr Carroll's death that "*I do not think that this death by suicide was preventable".* I accept his assessment in that regard.

However, when critiquing the process used by those undertaking mental health assessments at the Arthur Gorrie Correctional Centre he suggested that the time between the initial assessment of the prisoner being at risk and the review of their status by the HRAT was too short. Dr Curtis suggests that a secondary observation system ought to be required so that a more valid assessment can be made as to the risk posed by the prisoner's reaction to his circumstances. I respectfully adopt this suggestion.

Recommendation 1 - Review of at risk re-assessment procedures

I recommend that authorities at the Arthur Gorrie Correctional Centre review the

mechanisms and procedures which they use to reassess prisoners who have previously been assessed to be "at risk" before the person is removed from close observation to ensure that the decision has a sufficient evidence base.

Dr Curtis also expressed concern about the workload of the HRAT. He is of the view that it would be impossible to effectively undertake 10 to 12 such a reviews in an hour as apparently routinely happened at the time of this death. Again I respectfully adopt his recommendation.

Recommendation 2 – Better resourcing of HRAT

I recommend that the operators of the Arthur Gorrie Correctional Centre review the resources of the HRAT to enable a more careful and extensive consideration of each of the matters that come before the team.

Hanging points

The Royal Commission into Aboriginal Deaths in Custody, 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. Obviously this had not occurred at the Arthur Gorrie Correctional Centre at the time of Mr Carroll's death.

I was advised the Department of Corrective Services that in fact only 63% of all cells currently in use are suicide resistant; that is, 15 years after the Government indicated it accepted the recommendation one third of all cells are still in a dangerous state.

Official statistics uncontrovertibly 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.

In this case, the prisoner hung himself from bars in the cell wall. Obviously those bars could easily be covered with mesh that would have minimal impact on ventilation while eliminating them as a hanging point. 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.

Recommendation 3 – Removal of hanging points

I recommend that as a matter of urgency the Department of Corrective Services cause the cells at the Arthur Gorrie Correctional Centre to be modified to remove hanging points.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
19 January 2007