CORONERS COURT OF QUEENSLAND
FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Garry Ronald Appleton**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/1749
DELIVERED ON:	8 May 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 January 2017; 10 April – 13 April 2017 and 21-24 August 2017. Written submissions January to April 2018.
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; razor blade; provision of razor blades to prisoners, suicide risk assessment, information sharing.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper and Mr Daniel Bartlett
Queensland Corrective Services:	Ms Kylie Hillard, instructed by DJAG
Mr Appleton's family:	Mr Scott Collins and Ms Kate Greenwood, instructed by Aboriginal and Torres Strait Islander Legal Service
Muriel Simmons:	Dr Gavan Palk
West Moreton Hospital & Health Service:	Mr Aaron Suthers

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Introduction

1. Garry Ronald Appleton was 48 years of age when he was found semi-conscious in his cell at the Brisbane Correctional Centre (BCC) on the morning of 9 May 2015. He was slumped in a sitting position and there was a large amount of blood throughout the cell. Medical staff arrived and the nurses began treatment including the application of compression to wounds located on his arms.

2. The QAS attended and resuscitation efforts commenced. Mr Appleton was declared deceased at 12:17pm, by which time his heart had ceased beating for over 40 minutes. A dismantled disposable razor was found within the cell.

3. Mr Appleton had a long history of mental illness and imprisonment. He had been returned to prison on 30 April 2015 after an arrest warrant was executed at the Ipswich probation and parole office relating to a breach of his parole.

4. These findings:

   - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
   - consider the adequacy and appropriateness of the health care (including mental health care) provided to Mr Appleton on his arrival at BCC on 1 May 2015; and
   - consider the availability of razor blades to prisoners in Queensland correctional facilities.

5. The issue relating to the availability of razor blades to prisoners was examined conjointly at the inquest into the death of Terrence Michael Malone which occurred at the BCC in November 2014. These findings should be read in conjunction with the findings and recommendations in relation to Mr Malone's death.

The Investigation

6. The circumstances leading to Mr Appleton's death were investigated by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The investigation was led by Detective Sergeant Andy Seery, who has since retired from the QPS. He submitted a report to my Office and this was tendered at the inquest.

7. Detective Sergeant Seery attended BCC with several other CSIU officers. He inspected the cell and oversaw the forensic examination of all points of interest.

8. CSIU officers commenced the process of taking statements from staff and inmates of the relevant unit. They took steps to seize all relevant records and interrogated the BCC Integrated Offender Management System

(IOMS). Detective Sergeant Seery spoke to intelligence officers at BCC and made arrangements for statements to be obtained from senior officials at the prison. He also seized relevant CCTV footage. Scenes of crime officers took a series of photographs of the scene.

9. In addition to the QPS CSIU investigation, the Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by s 294 of the *Corrective Services Act 2006*. Those investigators prepared a thorough report which was submitted to the Office of the Chief Inspector (the OCI). It examined matters within and beyond the scope of the coronial inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings.

10. I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

11. A pre-inquest conference was held in Brisbane on 24 January 2017. Miss Cooper appeared as counsel assisting and leave to appear was granted to Queensland Corrective Services and representatives from the Aboriginal and Torres Strait Islander Legal Service (ATSILS).

12. An inquest was held over the weeks of 10 – 13 April 2017 and 21-24 August 2017. All of the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigations were tendered at the inquest. Written submissions were subsequently provided by counsel assisting and those granted leave to appear between January 2018 and April 2018.

13. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

14. Mr Appleton was an Indigenous man who had a long criminal history in Queensland dating back to his childhood in the 1970's. The majority of his offending was property related, with the occasional assault and drug related offence.

15. Mr Appleton's brother, Terry Bishop, provided a statement to the inquest.[1] He explained that his brother was born in Victoria, but raised in Queensland. Mr Appleton was the fourth of thirteen children. He had five brothers and seven sisters.

[1] Exhibit B2.

16. Mr Bishop recalled that his brother spent a lot of time in youth detention while he was growing up. As an adult, he continued to go to jail on a regular basis. Mr Bishop was aware that his brother was a user of heroin and methamphetamines. He did not recall his brother ever being employed in any capacity.

17. Mr Bishop recalled the last time he saw his brother was a few days before he went back to jail in April 2015. He described his brother as frail and unhealthy at that time. Mr Bishop knew that his brother had tried to take his own life before in prison, but he did not think he intended to do so on this occasion. Rather, he was trying to get himself placed in hospital.

18. Mr Appleton's partner of seven years was Ms Karen Isaacs. She provided a statement to the inquest in which she said that she and Mr Appleton were planning to get married. Her evidence was that when Mr Appleton went back to the prison she was not worried about him, as he had "*been there heaps of times and he was only there on a sanction*."[2] Ms Isaacs expected him to be home in about six weeks.

19. Ms Isaacs provided a copy of a letter she received from Mr Appleton, dated 5 May 2015.[3] In that letter, Mr Appleton spoke positively of their future together. He expressed that he missed his partner and sought reassurance that the relationship would endure the short time he expected to be in prison. Notwithstanding, Ms Isaacs believed Mr Appleton should have been on suicide watch from the time he was received at BCC.

Mental Health History

20. Mr Appleton's mental health history in the prison context was lengthy. He had been classified as a protection prisoner for many years, after reporting that he was raped at the Boggo Road prison in 1988 at age 19. His first admission to a psychiatric hospital was in the 1990s. At the time of a psychiatric review with Dr Prabal Kar in 2012, Mr Appleton said he had only been out of prison for only two years during his adult life.[4]

21. Mr Appleton reported to Dr Kar that he started taking drugs to "try and stop the voices." He had been diagnosed with schizophrenia, and had been admitted to psychiatric hospitals on four occasions. Dr Kar found that the diagnosis of schizophrenia was sound, due to the symptoms experienced by Mr Appleton, and the persistence of those symptoms when he was not taking illicit drugs. Dr Kar recommended that his psychosis be managed with antipsychotic medication and supporting adherence to treatment. Mr Appleton had demonstrated poor adherence to his treatment while he was in the community.

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[2] Exhibit B11.
[3] Exhibit B11.1.
[4] Exhibit D1.

22. The day he was arrested on the ‘return to prison’ warrant on 30 April 2015, Mr Appleton was taken from the Ipswich watch house to the Ipswich Hospital Emergency Department for review of an acute exacerbation of his previously diagnosed chronic obstructive pulmonary disease.[5] During that review, it was noted that Mr Appleton reported he had been hearing negative voices that morning. The reporting doctor noted that Mr Appleton seemed to have insight into this occurrence. He was then transferred to the Princess Alexandra Hospital (PAH) Secure Unit.[6] At the PAH, it was noted (with respect to his mental health) that for the past three days he had not taken his medication.[7]

Events leading up to the death

23. On 7 June 2013 and 7 August 2013 (after the sentence was reopened) Mr Appleton was sentenced to a three year period of imprisonment for the offence of armed robbery with personal violence. It is clear from the sentencing remarks that that he was “not behaving rationally” at the time of the offence.

24. Mr Appleton was released to parole on 7 June 2014. However, he was arrested on a ‘return to prison’ warrant on 30 April 2015 for breaching his parole, after the commission of traffic offences, including drink driving. It was determined that he had an elevated risk of reoffending, related to the additional offending and alcohol misuse. Mr Appleton had otherwise been compliant with the terms of his parole.

25. While the decision to suspend parole was not within the scope of the inquest into Mr Appleton’s death I note that it was not recommended by his supervising parole officer, and had the effect of requiring him to be returned to prison for a relatively short period of time. The IOMS notes relating to his attendance at the probation and parole office on 30 April 2015 record:

> *“Offender stated that he was hearing voices in his head and he sometimes drinks to take away these voices. He advised that on the date of his further offending, he had received bad news about his health. He advised that the doctors had found a mass in his stomach area and they don’t know what it is. The offender stated that he became really stressed about this and decided to have a few drinks.*

…

> *The offender presented as sad and nervous, which is reasonable given the circumstances. QPS attended the office to execute the warrant and Appleton began crying when he was told his order was being suspended. PPO stated to Appleton that ‘we would re-convene when he is released’ and try and work out a plan as to avoid this behaviour in the future.”*

[5] Exhibit D7; D5.2 page 40.
[6] Exhibit D5.2.
[7] Exhibit D5.2, page 35.

26. Mr Appleton was received at the BCC on 1 May 2015 and was placed in protection unit S6 until his transfer on 7 May 2015 to Unit S9.

27. Upon admission to BCC, all prisoners were required to undergo a medical assessment. Prisoners are questioned by nursing staff about their health status and a number of documents are completed. One of the documents is a 'screening tool for notification of concern'. This requires an assessment in relation to the offender's appearance, behaviour, conversation and suicidal ideation.

28. A further document is a 'medical in confidence' questionnaire. This is a detailed form that elicits information from the offender about their current medications, medical history, population health, drug and alcohol usage, mental health, self-harm and suicide risk and allergies or drug reactions.

29. Clinical Nurse Suzanne Golby administered the Prison Health Service medical in confidence questionnaire.[8] Mr Appleton was placed on medications consistent with those detected in his system post-mortem. He had been prescribed Prednisolone to assist with breathing difficulties, and an inhaler. Mr Appleton advised he had a history of self-harm while in custody, but denied any current suicidal ideation. A recommendation was made that he be referred to the PMHS and an appointment was booked for 7 May 2015 at 11:00am.

30. Further to the medical assessment conducted by Nurse Golby, an Immediate Risk Needs Assessment (IRNA) was also conducted by QCS Psychologist, Ms Muriel Simmons. She was interviewed for the purposes of the OCI report and this interview was tendered at the inquest.[9] Ms Simmons also gave evidence at the inquest, particularly with respect to the amount of information she accessed to complete her assessment. Ms Simmons has a master’s degree in Suicidology from Griffith University in addition to her qualifications as a psychologist. Ms Simmons has retired from working as a psychologist.

31. The OCI investigation noted that it was a requirement that when a prisoner is admitted to a Corrective Services facility an Immediate Risk Needs Assessment (IRNA) is conducted. The requirements for an IRNA were set out in the custodial operations practice directive for admission and induction. Those requirements include:

> *“(a) If it is identified during an IRNA that a prisoner presents with a history of self-harming behaviour or suicide attempts, a senior psychologist must be notified. The senior psychologist must activate the self-harm episode history (SHEH) warning indicator in IOMS in accordance with the assessment and planning practice directive. The relevant correctional supervisor must also be advised and then must ensure that the information is disseminated as soon as possible to all relevant staff members, including the senior psychologist.*

[8] Exhibit D6.1, page 4.
[9] Exhibit B25.

(b) A prisoner with a SHEH warning indicator in IOMS is to be accommodated in a suicide-resistant cell unless other reasonable factors warrant against such placement.

(c) The prisoner's records, IOMS (both previous custodial and community-based episodes), should be accessed to ascertain the prisoner's self-harm and suicidal behavioural history and psychiatric and psychological history.

(d) If it is identified during the IRNA that a prisoner has a history or a current diagnosis of mental illness, or has had previous conduct with a Mental Health Service provider, including immediately prior to admission to custody the assessing officer must make a referral to Prison Mental Health Service for assessment."[10]

32. Ms Simmons noted that Mr Appleton had a history of self-harm, but no relevant history since 2008. During her interview with OCI investigators, Ms Simmons emphasised the high percentage of prisoners who have a history of self-harm. She also made clear that the IRNA process assesses prisoners on how they present at that point in time.[11] Ms Simmons assessed Mr Appleton's immediate risk of suicide as being low.

33. During her interview with OCI investigators, Ms Simmons made note of the following matters of relevance which arose from the IRNA she completed:

    - The transporting officer did not indicate Mr Appleton may be at risk of suicide or self-harm;
    - Mr Appleton indicated that he typically self-harmed while experiencing psychotic features (auditory hallucinations) or an unstable mood;
    - Mr Appleton reported that he was medication compliant and further medication was effective in helping to manage his condition;
    - Mr Appleton reported that he had a terminal diagnosis;
    - Mr Appleton denied that he was feeling hopeless, helpless, or anxious and he was not exhibiting any overt indicators to suggest otherwise.

34. During the OCI interview, Ms Simmons emphasised that Mr Appleton appeared very concerned about his health. She stated that she confirmed with the relevant nurse that a referral to Prison Mental Health Service had been made. She also sent an email to the cultural liaison officer, Don Williams, on 4 May 2015 to the effect that Mr Appleton had some medical issues and would probably appreciate some support.[12]

35. The OCI investigators also spoke with Mr Williams, who recalled seeing Mr Appleton on 4 May 2015, and that he appeared to be doing "okay". There was a short discussion between them. Mr Williams thought Mr Appleton "still had a spark in his eye". Mr Appleton did not tell him about any mental health issues and Mr Williams did not have any concerns.[13]

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[10] Exhibit C8, page 8.
[11] Exhibit B25, page 4; 6.
[12] Exhibit B25, page 14.
[13] Exhibit C8, page 11.

36. At the inquest Ms Simmons said that before she assessed Mr Appleton, she spent a few minutes reviewing his recent IRNAs and self-harm history, noting that there was a lot of information in the database. In the IRNA completed on 1 May 2015, Ms Simmons noted that Mr Appleton had disclosed a history of self-harm (slashing) but stated that he had not harmed himself since 2007 or 2008. She agreed that his QCS records that were accessible at the time of her assessment noted that he had attempted suicide in 2012.[14] Ms Simmonds said that she did not have access to Mr Appleton's self-report of 30 April 2015 that he was hearing voices as that information had not yet been entered into IOMS.

37. Ms Simmons said that when she asked Mr Appleton about his history of self-harm he indicated that it was related to non-compliance with his medication regime. She said that he told her that he had support in the community and he denied all suicide self-harm ideation, intent and plan at the point in time she assessed him. He also denied hearing voices and she did not think he was psychotic. Mr Appleton also told her that he had a terminal lung disease.

38. Ms Simmons said that when a prisoner was assessed a psychologist could only take into account their mental state at that particular time. A prisoner's access to razor blades was not something she factored into her risk assessment, and only prisoners on 15 minute observations were prevented from having access to razor blades.[15]

39. On the morning of 7 May 2015, a medical emergency was called for Mr Appleton after he experienced shortness of breath. He was found by correctional officers sitting on the floor with a flushed face and having difficulty talking. His diagnosis of emphysema was noted. His oxygen saturations were recorded as being 98% on room air. He was placed on additional oxygen. It was apparent that Mr Appleton had experienced a panic attack over an imminent transfer to Unit S9.[16] He told correctional officers that he felt safer in his current unit and that S6 was "closer to the oxygen".

40. Mr Appleton's scheduled appointment with the PMHS did not occur as a consequence of this medical emergency and the relevant file notes state he was to be rescheduled for further intake.[17]

41. At 07:20am on 9 May 2015, correctional officers were performing the daily unlock of units to release prisoners into the unit block for breakfast and exercise. Mr Appleton slipped a note under his cell door which was read by the Custodial Corrections Officer ('CCO') Porter. A statement from Mr Porter was tendered at the inquest.[18] Mr Porter said that he spoke with Mr

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[14] T4, p24
[15] T4, p47
[16] Exhibit D6.1, page 13.
[17] Exhibit D6.1, page 16.
[18] Exhibit B17.

Appleton about the note, a copy of which was tendered at the inquest.[19] Mr Appleton told the CCOs that there had been prisoners tunnelling into his cell the previous night and pointed to the pin board on his wall to indicate where the tunnelling had occurred. Mr Appleton was asked if he wanted some time out in his cell. He replied he did not, and that he was not having any thoughts of self-harm.

42. CCO Porter told OCI investigators that he would have reacted differently had he been aware of Mr Appleton's mental health background. He did not know that he had been diagnosed with schizophrenia, had a history of hallucinations, and that he had told the psychologist during the IRNA that he has thoughts of self-harm when he has auditory hallucinations. CCO Porter said that if he had known these things he would not have permitted Mr Appleton to return to his cell, but would have kept him within a line of sight, raised a Notification of Concern and arranged for his transfer to the observations unit.

43. Just after 10:00am, Mr Appleton approached correctional officers and asked if he could go to his cell to rest. This request was agreed to, and Mr Appleton was secured in his cell while the other prisoners in his unit were engaged in various activities. Interviews with a number of prisoners were tendered at the inquest.[20] Some prisoners recalled hearing a prisoner calling out for help. After some time, one of the prisoners became concerned and went to Mr Appleton's cell, where he observed blood coming from under the cell door. He notified correctional staff.

44. CCO Porter attended at the cell and saw Mr Appleton in a sitting position beneath the door. CCO Porter described Mr Appleton to appear slumped and semi-conscious.[21] Mr Appleton was not leaning against anything, and blood was throughout the cell. A Code Blue was called as was the Queensland Ambulance Service (QAS). Medical staff arrived within minutes and nurses began treatment including the application of compression to the wounds located on the left and right antecubital fossa.

45. Attendance by the QAS included a critical care paramedic. At 12:17pm it was determined that Mr Appleton's heart had ceased beating for some 40 minutes, and he was declared deceased.

46. It became apparent soon afterwards that Mr Appleton had used a prison-issue disposable razor which he had dismantled.[22]

[19] Exhibit C7.
[20] Exhibits E1 – E34.
[21] Exhibit B17, paragraph 16.
[22] Exhibit F1, page 40.

Autopsy results

47. A full internal autopsy was conducted by forensic pathologist Dr Philip Storey on 12 May 2015. A report from Dr Storey was tendered at the inquest.[23]

48. External examination showed two significant areas of injury:

- Sharp-force injury to both forearms – examination showed that, though reasonably superficial, several of these wounds had transected the underlying brachial and radial arteries.

- Blunt force injuries to the chest wall – these comprised of sternal and rib fractures, a laceration to the pericardium and a laceration to the right atrium, likely as a result of resuscitation efforts.

49. With respect to the injuries to the forearms, Dr Storey said that the scene was consistent the loss of a large amount of blood rapidly. Dr Storey confirmed that the forearm injuries were immediately life threatening, and required the application of pressure to stem any ongoing blood loss, and the correction of any circulatory shock which may have taken place.

50. Given the significant chest trauma, Dr Storey considered whether or not the internal loss of blood from the circulation secondary to the resuscitation trauma was a significant factor in the death. Dr Storey noted that there was already significant blood loss, well in excess of one litre, before Mr Appleton became unconscious. Dr Storey concluded that this blood loss was entirely contributed to from the forearm injuries, and not as a result of internal bleeding into the chest.

51. Severe natural disease was also noticed, involving the coronary arteries and emphysema. Dr Storey confirmed that together, these two diseases would have impinged on the ability of the lungs to supply the blood with oxygen during a state of significant blood loss; and lowered the threshold for the heart rhythm to decay into a life-threatening arrhythmia.

52. Dr Storey determined the cause of death to be:

    1(a) Hypovolaemic shock, due to or as a consequence of;
    1(b) Incised wounds to the arms.

    Other significant conditions:

    2. Coronary atherosclerosis, emphysema.

[23] Exhibit A5.

Adequacy and appropriateness of the mental health care provided to Mr Appleton

53. As noted above, I heard evidence from Ms Simmons regarding the IRNA conducted on Mr Appleton on 1 May 2015. The OCI report made a total of five findings relating to the adequacy of the IRNA conducted by Ms Simmons with regard to:

    1. Whether a Notification of Concern should have been raised with respect to Mr Appleton in the days before his death;
    2. Whether Mr Appleton's psychiatric needs were met; and
    3. Whether the response to Mr Appleton's indicators of risk was adequate.

54. The incident findings contained within the OCI Report can be summarised as follows:

    1. The IRNA was not procedurally compliant and was not robust in considering relevant factors to identify at risk indicators; including Mr Appleton's self report of hallucinations on 30 April 2015. A more thorough assessment would have resulted in risk management planning or closer monitoring.

    2. There was a failure to raise a notification of concern when Mr Appleton was observed to be highly anxious when advised he was being moved from Unit S6 to Unit S9.

    3. There was a failure to report the Medical Emergency Incident when the Code Blue was called in S6 when Mr Appleton was suffering an anxiety attack.

    4. Mr Appleton's medication and psychiatric needs were possibly not met or assessed; and

    5. There was an inappropriate response to the indicators of risk by unit staff on 7 May 2015.

55. Dr Choudhary, Consultant Psychiatrist and Deputy Director of Medical Services with the Metro North HHS provided a statement to the effect that, while he could not comment on the overall adequacy of Ms Simmons' IRNA on 1 May 2015, it appeared that her assessment was thorough and Mr Appleton was not a high risk of self-harm at the time of the assessment.

56. Dr Choudhary noted that Ms Simmons had made appropriate referrals to the PMHS. As he did not consider that Mr Appleton was hallucinating when he was assessed by Ms Simmons, he did not consider that the outcome would have been any different if she had access to the information recorded by Ms Comancho on 30 April 2015 about auditory hallucinations. Dr Choudhary also doubted whether Mr Appleton's reference to hallucinations on 30 April 2015 was reliable because there was no evidence that staff members at the Ipswich Hospital or the PAH noticed objective symptoms of this.

57. However, Dr Choudhary also stated that Mr Appleton's risk significantly increased from 7 May 2015 due to his:

    a) past history of suicide attempts and self-harm attempts,
    b) recent incarceration,
    c) medical diagnosis, and
    d) heightened level of anxiety in relation to the move from Unit 6 to Unit 9, which led to a Code Blue being called.

58. Dr Choudhary thought that on 9 May 2015, Mr Appleton developed clear signs of mental health deterioration, including delusional beliefs about prisoners tunnelling in his cell to escape and his medication being 'stuffed'. Dr Choudhary opined that these statements suggested evidence of the development of psychotic features in the form of delusions and possibly hallucinations. In my view, the obvious deterioration in Mr Appleton's mental health would likely have nullified any protective factors identified by Ms Simmons.

59. I note that the finding in the OCI Report in relation to Ms Simmons' IRNA was premised on Ms Simmons not reviewing the IOMS record that Mr Appleton had been having hallucinations the previous day. I accept that this information was not available to Ms Simmons at the time of her assessment. Having regard to the evidence of Dr Choudhary, I consider that Ms Simmons assessment of Mr Appleton's risk of suicide when she saw him on 1 May 2015 was adequate, and that she took appropriate steps to link him with the cultural liaison officer and the PMHS.

60. Unfortunately, there was a failure to recognise and respond to the significant deterioration in Mr Appleton's mental health and the associated escalation in his suicide risk which was identified by Dr Choudhary as occurring after 7 May 2015. I agree with Dr Choudhary that the Code Blue on 7 May 2015 was primarily connected with Mr Appleton's heightened anxiety about being moved to Unit S9, and that it was not appropriate to cancel his PMHS appointment on that day.

61. I also agree with the conclusion in the OCI Report that there was a failure to raise a notification of concern after the Code Blue. As the OCI Report indicated, a notification of concern would likely have resulted in an 'at risk' plan being required and Mr Appleton being prioritised for intake with Prisoner Mental Health Services. There was also a failure in communicating information relevant to Mr Appleton's level of risk to the officers in Units S6 and S9 who were responsible for his day to day care.

62. I am satisfied that Mr Appleton died by his own actions of cutting his forearms with a prison-issued razor blade. Mr Appleton's actions in calling for help after the self-harm incident lead me to conclude that he did not intend to kill himself. Mr Appleton's death might have been prevented if, having regard to his dynamic risk factor and his mental health history including the specific nature of previous self-harm episodes, he had been

prevented from having a razor blade issued to him by the prison or placed on an at risk observations regime.

Provision of razor blades to prisoners

63. Given the circumstances of Mr Appleton's death, the issue of the availability of razor blades to prisoners in custody was investigated at the inquest conjointly with the inquest into the death of Mr Terrence Michael Malone. I refer to the consideration of this issue in the inquest findings in relation to the death of Mr Malone.

64. In the 2013 inquest into the death in custody of Lawrence McCarty before the former State Coroner, Counsel for QCS explained that providing disposable razors and toothbrushes to all prisoners in the mainstream population commenced in 2010 to assist in the prevention of the spread of communicable diseases. At that inquest, counsel for QCS had submitted that the dismantling of razors had been identified as a risk and steps were in place to manage the risk.

65. As was the case with Mr Malone, Mr Appleton was allowed to have the razor blade, and was provided with it on his reception to the BCC.

Findings required by s45

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

Identity of the deceased – The deceased person was Garry Ronald Appleton.

How he died - Mr Appleton was returned to prison after his parole was suspended on 30 April 2015. He was assessed as being at low risk of suicide when admitted to the Brisbane Correctional Centre on 1 May 2015. Mr Appleton experienced a significant deterioration in his mental health after 7 May 2015 and was exhibiting signs of psychosis as well as heightened anxiety after being moved between units. He unintentionally died as a result of his cutting his own forearms with a prison-issued razor blade while alone in his cell.

Place of death – Brisbane Correctional Centre, Wacol in the State of Queensland.

Date of death – 9 May 2015.

Cause of death – Mr Appleton died from hypovolaemic shock, due to or as a consequence of incised wounds to the arms. Other significant conditions were coronary atherosclerosis and emphysema.

Comments and recommendations

67. Section 46 of the *Coroners Act 2003*, 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.

68. The OCI Report made a number of recommendations, as did Detective Sergeant Seery in his report regarding the initial assessment conducted on prisoners. In response to those recommendations, I was assisted at the inquest by a statement from Mr Peter Shaddock, General Manager, Custodial Operations, State Wide Operations, QCS.[24] I also heard oral evidence from Mr Shaddock. Mr Shaddock explained that the QCS oversight committee had accepted all recommendations from the OCI report.

69. Recommendation 1 is as follows –

"That a review of the assessment volume and workload be undertaken at BCC and that resourcing be provided to meet the assessment workload needs. While it is appreciated that BCC has provided an additional professional (P03) resource to perform collateral checking of information, a review should ensure that the position is unrestrained and utilised for this purpose."

70. Mr Shaddock confirmed in his evidence that a review had been conducted at BCC with a view to arriving at a resourcing model which would meet the assessment workload needs. The review found that the difference in workload at BCC between 2014 and 2016 represented the equivalent of 1.5 full time employees to address the increased work demands on psychological staff.

71. Shortly before Mr Appleton's death, BCC created a new psychologist role whose sole responsibility was to complete collateral checks and review the electronic record keeping system (IOMS). This was done so that all relevant history could be provided to the assessing psychologist prior to the arrival of a new prisoner.

72. Recommendation 2 is as follows –

"Regular professional development and training opportunities to be either sourced or developed, which give guidance on assessment practices aimed at expanding the current approach of the IRNA practice.

Hold regular practice development type forums with psychological assessing staff as a learning opportunity (similarly used within Probation and Parole) lead by the Senior Practitioner. The aim is to provide staff with an opportunity to present and discuss difficult assessments, assessment strategies used, sources of additional information and services which they found useful for support."

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[24] Exhibits B26 – B26.16.

73. Mr Shaddock explained that there had been a concerted effort in BCC to facilitate training and to reinforce the most effective way to manage the assessment process. He gave evidence that training had been provided in specially designed sessions, concentrating on specific assessment skills in the IRNA. Training sessions are held throughout the year and all psychologists are expected to attend.

Recommendation 3 –

"The centre reviews the mentoring strategy of new officers to ensure that new officers are provided with appropriate support and mentoring to guide decision making."

74. Mr Shaddock's evidence was that BCC has adopted a more concerted effort to ensure that new staff are rostered on with more experienced staff; that new staff are briefed by area supervisors each day and are encouraged to contact supervisors if they have any uncertainties; and all staff are provided with mandatory suicide prevention training.

Recommendation 4 –

"The centre provides refresher training on the reporting expectations which are outlined in the agency procedure."

Recommendation 5 –

"Local:
1. Brisbane Correctional Centre management review stakeholder mechanisms for local QCS Psychology Team/ QHealth/ PMHS collaboration which incorporates case review of newly receipted prisoners and PMHS intake priority. This should incorporate the centre psychology team having regular meetings with PMHS to discuss new receptions and PMHS intakes to ensure everyone has the relevant information. The forum should aim at discussing relevant information in regards to new centre receptions and PMHS intakes to inform both areas and their respective processes (aid PMHS intake prioritisation and QCS risk management).

System:
1. *QCS undertake a review of whether current and proposed policies, procedures and agreements sufficiently facilitate the sharing of information between all Hospital and Health Services, PMHS, QCS and/or the private prison providers.*
2. *Review the effectiveness of collaboration between QCS and QHealth with the aim of improving information sharing to enhance offender outcomes and optimise service delivery for both parties."*

75. Mr Shaddock confirmed that the PMHS is now able to attend daily operations meetings, and are able to point out risks associated with prisoners on the day of intake.

Recommendation 6 –

"The centre reviews unit handover processes to ensure that full and proper information regarding new prisoners is provided to individual accommodation units. This should include notes on IRNA assessment, previous incidents and case notes."

76. Mr Shaddock explained that, as a result of this recommendation, consideration is being given to provide for the IRNA summary information to be placed on an easily accessible tab within the electronic system. This would result in officers being able to more readily look up information, especially in induction units which generally have a high prisoner turnover rate.

77. Mr Shaddock gave evidence that, in order to achieve this, the electronic filing system would need to be re-configured. This is something which is outside of the ability of State Wide Operations to influence.

Recommendation 7 –

"A technical solution is explored where a prisoner's individual risks and behaviours can be reviewed quickly and centrally by front line staff. E.g. The Self Harm Suicide warning flag has a text box that displays when clicked. Staff can enter text in the text box such as:

"Offender self-reports self-harm/ suicide thoughts associated with auditory hallucinations"."

78. Mr Shaddock confirmed that a 'Software Change Request' to include 'Offender Warnings and Notes' page on the front screen of IOMS has been requested since December 2012. This request was endorsed again in April 2015.

79. Mr Shaddock explained that the change was originally to be included in software updates predicted for February 2017, however, these changes have had to be postponed, but remain a priority.

80. I am satisfied that the recommendations already made by the OCI and the actions taken with respect to them, would make a significant contribution towards preventing a death in similar circumstances to Mr Appleton from happening again.

81. Submissions on behalf of Mr Appleton's family supported the implementation of all the recommendations from the OCI Report, noting that the training under recommendation 2 should also incorporate an understanding of cultural safety with respect to assessment by medical professionals unfamiliar with ATSI cultural issues.

82. Mr Appleton's family also submitted that I should make the following additional recommendations to complement those within the OCI Report:

- *As a matter of urgency, the BCC and QCS adopt the S1, S2, S3 self harm scale used by Queensland watch houses to identify prisoners at risk;*
- *as a matter of urgency the BCC and QCS create a procedure to have a handover of information from the watchhouse to facilitate transfer of information concerning prisoners already identified as being at risk;*
- *that the Queensland government consider a similar policy and procedure to the New Zealand model regarding prisoners being given access to disposable razors.*

83. Mr Appleton's family did not agree with Mr Shaddock's evidence that the IRNA process was robust and submitted that it was prone to fail for the reasons it failed in Mr Appleton's circumstances. Mr Appleton's family considered that the failure in the process was not attributable to the actions of individual clinicians at the BCC, and it was important to consider not "who blundered, but how and why the defences failed". It was submitted that systemic solutions would guard against individual failures that led to the death of Mr Appleton and Mr Malone. I agree with that submission.

84. I also agree with the family's submission that significant recent increases in the prison population will place added pressure on the current processes to identify and respond to suicide risk. In my view, the recommendations below respond to the concerns of Mr Appleton's family and complement the recommendations within the Chief Inspector's Report.

Recommendations

85. I restate the following recommendations arising from the inquest into the death of Terrence Malone that are also relevant to the circumstances of Mr Appleton's death:

1. *I recommend that Queensland Corrective Services develops a policy in relation to the management of the risks associated with the provision of razor blades to prisoners within the first month of entry to prison, particularly where a prisoner has recently expressed suicidal ideation or has recently been discharged from a hospital emergency department following an Emergency Examination Authority.*

2. *I recommend that Queensland Corrective Services, in partnership with Queensland Health, reviews its approach to suicide risk assessment and assertive responses to suicide risk in the context of best practice approaches.*

3. *I recommend that these findings be provided to the Queensland Mental Health Commission and the Strategic Leadership Group overseeing the implementation of the Mental Health, Alcohol and Other Drugs Strategic Plan with a view to informing the enhancement of responses to persons with co-occurring mental illness and substance use disorders who are at risk of entering or have entered the criminal justice system.*

4. *I recommend that the Queensland Government considers an increase in funding to enable QCS to enhance the IOMS system to support the recommendations of the Office of the Chief Inspector to enable risk assessment information to be displayed and accessible for QCS staff within a drop down menu.*

5. *I recommend that the Queensland Government consider an increase in funding to enable QCS to be a competitive employer to attract and retain experienced psychologists and senior psychologists within custodial settings.*

6. *I recommend that the Queensland Government consider a trial program for "Front End Services" of intake, health assessment and mental health assessment at the Brisbane City watch house that involves collaboration between relevant stakeholders, including Queensland Corrective Services, Queensland Health, the Queensland Police Service and the Prison Mental Health Service.*

86. I extend my condolences to Mr Appleton's family. I close the inquest.

Terry Ryan
State Coroner
Brisbane
8 May 2019