OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tofia Josen MATAIA**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Rockhampton
FILE NO(s):	COR 6334/08(3)
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HEARING DATE(s):	30 March 2010, 21-24 June 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, restraint asphyxia, managing prisoners with mental illness, emergency responses

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
CCO's Amanda Andrienko, Bevan Woder, Adam Gee, Richard Mielland, Grant Boyd, Dan Reed, Jeff Smith and John Devenish:	Mr Simon Lewis (instructed by Reeves Lawyers)
Queensland Health:	Mr Kevin Parrott
Department of Community Safety:	Mr Russell Byrnes
Nurses Pauline & Judy Gaille:	Mr Brad Farr SC (instructed by Cooper Grace Ward Lawyers)
Prisoners' Legal Service:	Ms Paula Morreau

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The *Coroners Act 2003* ('the Act') provides in s45 that a copy of inquest 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 including the Attorney-General and the Minister for Police, Corrective Services and Emergency Services. These are my findings in relation to the death of Tofia Josen Mataia. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

On 18 October 2008, Mr Mataia had been in custody at Capricornia Correctional Centre (CCC) for almost two months when, without warning or provocation, he punched a corrective service officer (CSO). He was restrained, handcuffed and marched by several officers to a cell in the detention unit (DU). He was placed on the ground, face down and held by the officers while they attempted to negotiate the removing of the handcuffs. He was noticed to be turning blue. He had stopped breathing and had no detectable pulse. CPR was attempted without success. Mr Mataia was declared dead by an ambulance officer a short time later.

This constitutes a "death in custody" under the Act. In such circumstances an inquest must be held by the state coroner or deputy state coroner.

This report:-

- Contains my findings as to the identity of the deceased person and when, where, and how he died and the medical cause of his death;

- Considers whether the conduct of any of those involved should be referred to the DPP or appropriate disciplinary bodies pursuant to s48 of the Act for determination of whether criminal or disciplinary charges should be preferred; and

- Considers whether any of the policies or procedures of the Queensland Corrective Services Commission or Queensland Health contributed to the death or should be change to improve public health and safety or the administration of justice.

The investigation

As can be readily appreciated, whenever a death in custody occurs it is essential the matter be thoroughly investigated to determine whether any inappropriate action by those charged with supervising the custody of the deceased may have contributed to the death. The family and friends of the deceased person are entitled to expect a thorough investigation and an account of how the death occurred. It is also desirable that the general public be fully apprised of the circumstances of the death so they can be assured the actions of the custodial officers has been appropriately scrutinised. The custodial officers involved also have a right to have an independent

assessment made of their actions so there can in future be no suggestion there has been any "cover up" of inappropriate action.

In this case, detectives from the Rockhampton Criminal Investigation Branch arrived at the CCC a little more than an hour after the death. They assumed responsibility for securing the cell block where the initial assault occurred and the Detention Unit cell where Mr Mataia died. Scenes of crime officers, forensic staff and police photographers attended at the centre, seized exhibits and recorded relevant events. Importantly, the CCTV footage recording much of the incident was also seized.

A number of aspects of these initial inquiries were unsatisfactory:-

- No attempt was made to isolate the officers who had been involved in the fatal incident. They were allowed to mingle together before being directed to return to their work stations. It seems likely in two cases the officers collaborated in preparing their reports.

- The clothes those officers were wearing were not seized until some four or five hours after the death providing an opportunity for contamination of their evidentiary value.

- Two of the corrective service officers (CSOs) refused to be interviewed by police. The reports they prepared were scant.

I will comment on these shortcomings and how they might be avoided in future cases later in this report.

The day after the death, officers from the Corrective Services Investigation Unit (CSIU) travelled to the CCC and assumed responsibility for the investigation. They obtained the files relating to Mr Mataia's incarceration in the CCC and Lotus Glen Correctional Centre (LGC) and his treatment by the Cairns Mental Health Unit.

An autopsy examination was conducted on the body of Mr Mataia on 20 October by an experienced pathologist, Dr Beng Ong, during which blood and urine samples were taken from the deceased and subsequently analysed.

An investigation into the incident was commissioned pursuant to s.219 of the *Corrective Services Act 2000* (the Chief Inspector's investigation). I have had regard to the findings made as a result of that investigation. It appears to have incorporated a thorough review of relevant policy and procedure. I will also comment on the recommendations made as part of that investigation and the extent to which they have been adopted.

I am satisfied that this matter has been thoroughly and professionally investigated and that all relevant sources of information have been accessed and analysed. Detective Sergeant Lori Hicks compiled a comprehensive report that was of great assistance. I thank her for her efforts.

The inquest

The inquest was opened with a pre-inquest conference on 30 March 2010. Mr Johns was appointed counsel assisting and leave to appear was granted to Queensland Health, the Department of Community Safety, and the CSOs involved in the incident. Pursuant to s36(2) the Prisoners Legal Service was given limited leave to pursue issues of public interest. Leave to appear was later granted to two nurses involved in attempting to resuscitate Mr Mataia.

The inquest was convened in Rockhampton on 21 June 2010 and evidence was heard over the following four days. In all, 21 witnesses were called to give evidence. All coronial documents, statements, expert reports and custodial records were tendered. I was also greatly assisted by written submissions provided by each of the persons granted leave to appear.

The evidence

I turn now to the evidence. I have not summarised 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

Social history

I did not receive detailed biographical information about Mr Mataia's early life, but the following has been gleaned from various departmental records.

Tofia Mataia was born in Samoa on 26 April 1976, making him 32 at the time of his death. When he was 11, he moved to New Zealand with his mother and other relatives. He married when he was 19 and had three children who were aged 12, 10 and 8 when their father died. Their mother, Tofia's wife, died in 2006.

Mr Mataia and his wife moved to Australia in 2003 but they separated soon after.

For just under a year prior to his death, Mr Mataia had been living with his brother and his brother's family in Cairns.

Criminal and mental health history

I received no evidence as to whether Mr Mataia had been convicted of any criminal offences in New Zealand. It is clear, however, that soon after he arrived in Australia he persistently engaged in relatively minor criminal activity, and this continued up until his death. It seems that on almost every occasion his offending behaviour was precipitated by, linked to, or associated with his mental illness which I shall adumbrate next.

In December 2004, Mr Mataia was charged with property offences and assaulting police as a result of two separate incidents in New South Wales. He was remanded in custody. When the charges were dealt with in April of the following year he was, by order of the court, admitted to the Rozelle Hospital

under a provision in that state's Mental Health Act. He remained there for three months during which time he assaulted numerous staff and other patients. Accordingly, in June 2005, he was transferred to the Morisset Psychiatric Hospital where he was housed in the Kestrel Unit - a medium secure unit for long term, difficult to rehabilitate offenders suffering from acute or chronic mental illness.

Within hours of arriving at Morisset, Mr Mataia assaulted a nurse. He was put into the seclusion unit for five days. When brought back into the ward he again immediately assaulted a nurse and was returned to the seclusion unit where he remained for 18 months. A feature of these assaults was that they were unexpected and unprovoked.

Mr Mataia was diagnosed with schizophrenia with a strong affective component and deficit in formal lobe function, thought to be the result of an acquired brain injury.

He showed no outward signs of aggression from January 2007 and in March of that year his reintegration into the main ward was commenced. In August 2007, Mr Mataia was transferred back to Rozelle with a view to further stabilising and return to the community.

On 4 November 2007, his case manager at Rozelle sought an extension of his Continued Treatment Patient Order to regulate him while arrangements were being made for Mr Mataia to be released into the care of his brother in Cairns. His medical file was transferred to the community mental health service in that city. He was transferred as an involuntary patient.

Treatment by Cairns MHU

Later that month Mr Mataia was assessed at the Cairns Base Hospital Mental Health Unit where he was found to be settled and content with his medication and general situation. He exhibited no aggression or anxiety. He was then taking sodium volparate - 1000mg bd, respiridone – 6mg bd, propranolol – 80mg bd, sertraline – 150 mg mane and simbastatin – 20mg notcte. Those mediations were continued.

He was seen again in early December when, alarmingly, he told a case worker that he wasn't sick anymore and didn't need to continue his medication or contact with the service. However, he agreed to be reviewed by a psychiatrist on the following day. At this review, he told the doctor he had ceased taking his medication some two weeks earlier. He was warned of the risk of doing this but was not admitted to the hospital. A "wait and see" plan was formulated with a low admission threshold if his brother contacted the service with concerns about violence.

Mr Mataia apparently did not come to the attention of either the police or mental health services for the next six months. During that time he was apparently living with his brother largely without incident, although his brother reported occasions on which Mr Mataia became obstreperous when drinking.

On 5 June 2008, he came to the attention of police when found in a yard, laughing manically and acting in an aggressive and threatening manner. He was taken to the Cairns Mental Health Unit and made the subject of an involuntary treatment order (ITO). He was assessed to be psychotic - characterised by grandiose and religious delusions, disorganised thought patterns and poor insight.

He was again medicated but did not settle. On a number of occasions in the following months, he absconded and had to be brought back by police, often affected by alcohol or drugs. He was noted to become aggressive and threatening when agitated and assaulted police, staff and patients on numerous occasions.

On 15 August 2008 his ITO status was changed to "community" and he was allowed to return to live with his brother. In a discharge summary retrospectively created after Mr Mataia's death, it was claimed he had "*made slow but steady progress on the ward".* This sits uncomfortably with an entry made on the day of his release which records; "*Tofia, unprovoked punched co client (name omitted) in the face again."* A similar entry was made two days earlier.

In any event, he was released into the care of his brother, with a supply of medication and an expectation that the community mental health team would have on going contact.

Strangely, he presented at the Cairns Base Hospital Emergency Department the next night requesting assessment of his psychiatric disorder, but left before any treatment could be provided.

It seems from the records that over the next week the team attempted to telephone and visit Tofia, only to lean from his brother that on 22 August he had left the home on the night of his discharge and had not been seen by him since.

In fact, by this stage, Mr Mataia was already in police custody, and he was never thereafter released.

On 18 August he was located inside premises in Cairns and charged with breaking and entering and wilful damage. He was granted watch house bail, but when signing the necessary paperwork, suddenly and without provocation or warning, he assaulted a police officer in the watch house. He was charged with serious assault and brought before the Cairns Magistrates Court the following day. The Court was not made aware of the extant ITO and he was remanded in custody. Mr Mataia was transferred to the LGCC on 21 August 2008.

Lotus Glen Correctional Centre

Soon after arrival at the LGCC an initial risks and needs assessment (IRNA) was undertaken by Barry Stormont, a first year provisional psychologist in his first professional position. Mr Stormont said he saw on the list of incoming prisoners, the word "*violent*" beside Mr Mataia's name and recalled one of the transport staff mentioning that he had assaulted an officer at the watch house.

Mr Mataia denied having previous convictions for offences of violence and said he had not had any contact with mental health services within the last six months. However he acknowledged that he had received treatment in NSW at some time in the past.

Mr Stormont did not seek to confirm any of this information as he misapprehended he could only access the relevant health files under freedom of information legislation. Accordingly, he too failed to learn of the ITO. I accept the submission made on his behalf that he had a very short time frame in which to make the assessment and it was never envisaged he would be providing therapy to Mr Mataia.

Mr Stormont assessed Mr Mataia's "*institutional risk*" to be "nil", apparently placing no store on the report of his being violent in the watch house. He assessed his "*individual risk/needs*" as "*acute psychological needs*." Accordingly, he referred Mr Mataia for a mental health assessment by staff from Prisoner Mental Health.

The nurse who assessed his medical needs had more success in eliciting from him that he had recently been a patient at the Cairns Mental Health Unit and had been taking Zyprexa – 5 mg bd. This was therefore continued and the need for a mental health assessment confirmed. However, it seems this nurse did not contact the service as presumably, had she done so, she would have learned of the ITO.

Two days later, before the mental health assessment could be undertaken, Mr Mataia went to the prison health centre complaining of a headache. He was given analgesic and told to sit. Without warning, he assaulted an officer by pushing him hard to the face causing the officer to fall to the ground. He was transferred to the DU while arrangements were made to transfer him to the CCC in accordance with QCS policy following such incidents. This proceeded without any assessment of Mr Mataia's mental state.

Capricornia Correctional Centre

He arrived at the CCC on 25 August and was placed in the DU. The initial assessment noted no medical needs. He was seen by Dr Todorovic, a psychiatrist two days later. He told the psychiatrist he had a long history of cannabis abuse which apparently led this doctor to conclude he suffered from drug induced psychosis. He prescribed Zyprexa - 10 mg twice per day. No attempt was made to obtain any medical records.

On the same day, an Acting Intelligence Analyst at the CCC spoke to a counter part at LGCC who advised her of Mr Mataia's propensity for violence. As a result she circulated an email to all CCC managers and supervisors advising that Mr Mataia had a mental health history. She also described the assaults at the Cairns watch house and the LGCC. She passed on a warning from LGCC that officers should remain out of arms reach when dealing with this offender.

On 28 August the Acting Assistant General Manager made a Safety Order based on that information received from LGCC. It authorised Mr Mataia to be held in the DU until 25 September for the good order and security of the facility. It contained the warning that officers should stay out of arms reach. However, four days later on 29 August, Mark Nelson, the Manager of Secure emailed the Supervisor in charge of the Secure Custody Section, advising that he'd been told by the nurse unit manager that Mr Mataia's medication and behaviour were both satisfactory and stable and that he should be moved out of the DU. The Chief Inspectors investigation report said the Safety Order was apparently not cancelled by Mr Nelson until 8 September. It also concludes he had no authority to take either step. I agree.

In any event, on the afternoon of 29 August, Mr Mataia was moved to cell 14 in cell block S8. A note made in his case file on that day refers to the LGCC incident and recommends that officers maintain caution when dealing with him.

On 8 September he was again seen by Dr Todorovic and an anti depressant, Zoloft - 100mg, mane – was added to his medication regime on account of Mr Mataia exhibiting poor impulse control.

He is seen by another psychiatrist on 28 September. Mr Mataia was cooperative and happy with his medication and so no changes were made. The prison medical file indicates Mr Mataia received his prescribed medication throughout his time in the CCC and the inquest heard evidence of steps taken to ensure prisoners to whom medication is administered actually take it. Post mortem blood samples confirmed that Mr Mataia was medication compliant.

The case notes detailing the CSOs contact with him reveal nothing out of the ordinary and Mr Mataia was not involved in any incidents of note over the ensuing seven weeks.

The assault

On 18 October CSOs Adam Gee and Richard Mielland were working in cell block S8. Neither regularly worked in that unit and neither was aware of Mr Mataia's history of assaultive behaviour. Mr Gee's only other contact with him had occurred the day before when he assisted the prisoner with the paperwork needed to have names added to his approved telephone contacts. At about 9.00am on the morning of 18 October Mr Mataia thanked Mr Gee for this assistance.

At about 10.30am the officers commenced a muster which required the prisoners to stand by their cell doors so the officers could check the cells and count the prisoners. The first count did not accord with their expectations and so they commenced repeating it. Mr Mielland was on the upper level and Mr Gee was moving around the ground floor. He passed by Mr Mataia as he went to look into cell 13. Without warning, he was struck to the head from behind and to his left. He reeled away and saw that Mr Mataia was the assailant. He noticed the prisoner had a blank expression on his face and was not saying anything. The prisoner advanced towards him throwing more punches which the officer avoided as he yelled at the prisoner to stop and explain himself. Mr Mielland recognized the urgency in the shouting and rushed to the stairway. He saw Mr Gee backing away across the day room, being followed by Mr Mataia. He immediately called a code yellow over his radio - officer being assaulted - ran down stairs and yelled at Mr Mataia to desist. He got between the two. Mr Mataia directed his attention to Mr Mielland and almost immediately punched him in the face. Mr Mataia kept swinging blows as the two officers grappled with him and wrestled him to the ground.

An officer in Secure Control heard the code yellow called. He immediately over rode the electronic gate locks to allow those responding to the code easier access to S8. She also directed a colleague to activate a CCTV camera to record the activity in that cell block. As a result the inquest had the benefit of a visual recording of much, but not all, of what next transpired. It commences at 10:32.52.

The restraint

Messrs Gee and Mielland were able to stop Mr Mataia punching them, but only by lying on him and each holding an arm. He would not cease his resistance and they could not get sufficient control to handcuff and move him. Accordingly, they lay on the floor in a tense impasse awaiting the arrival of an emergency response team. On the CCTV footage, Mr Gee can be seen with his hand pressed against Mr Mataia's jaw, a precaution he said to prevent the prisoner spitting on the officers.

At 10:34.28, the five member first response team arrived. They immediately took over trying to control Mr Mataia. They rolled him onto his stomach and wrestled his arms behind his back. He apparently resisted this and two of the officers used knee strikes in an attempt to overcome this. The delivery of knee strikes to the thigh of a prisoner is a technique taught for use in such situations. Both officers claim these blows were delivered to Mr Mataia's thigh. In my opinion this is unlikely to be accurate: the officers are next to each other and clearly land blows to different parts of Mr Mataia's body. However, this is of little significance. The force used was not excessive in the circumstances and unlikely to cause serious injury.

One of the officers, Grant Boyd, can be seen kneeling with one knee on Mr Mataia's upper back as the handcuffs are being applied. At 10:36.30, Mr Mataia was lifted to his feet, his head was pushed down so that he was bent

at the waist as he was walked backwards out of the unit with officers on all sides holding him and guiding his movement.

The Supervisor Secure, Mr Chris Jasperson, a senior corrections officer, also came into the unit soon after the code yellow was called. He confirmed Mr Mataia should be taken to the DU, as would be usual in such cases. This involved moving him down two fenced walkways over a distance of about 150 to 180 metres. This area is not monitored by CCTV. The officers said in evidence that Mr Mataia continued to struggle as the group made their away along these walkways and he never became fully compliant. The officers said that for this reason they kept walking him backwards and bent over as that gave them greater control over him.

The videotape shows the group entering the DU at 10:40.12[1]. Mr Mataia is walked backwards down the corridor to cell 5. Unfortunately, the camera operator who attempted to switch to the camera in that cell had difficulty locating it and vision is lost for 25 seconds.

The officers said that when they entered the cell, Mr Mataia was lowered onto his knees and then to his stomach in preparation for the handcuffs being removed. When vision is restored at 10:41.25, five officers are surrounding and bending over Mr Mataia, completely excluding him from the picture. One can be seen bending Mr Mataia's lower legs towards his buttocks, one is at his head, two are on his right side and one is on the other side or astride him.

All of the officers said that when he was placed on the floor and held there, Mr Mataia was told they intended releasing his handcuffs one at a time and that he should place his freed hand on the back of his head. He was asked to acknowledge that instruction but failed to do so. All of the officers said that when the first hand cuff was released Mr Mataia did not put his hand on his head, although it is difficult to understand how he could have when being held. In any event, they decided to re-cuff him. Before they could do so, the officer in front of his head indicated Mr Mataia was not breathing and so he called a code blue. That officer, Lyle Semple, said in evidence that Mr Mataia had not been struggling from the time he was lowered onto the floor.

It was also apparent that Mr Mataia had been incontinent of urine.

Mr Boyd said in evidence that when Mr Mataia was on the floor of cell 5 *"he still seemed very tense and quite tight" and* when he failed to comply with the instruction to put his freed hand on his head it was decided to reapply the hand cuff that had been released in case the prisoner used it to attack them. Mr Boyd says he had hold of the prisoner's left arm. However, the CCTV footage shows his hands in various places, other than holding the prisoner's arm. At one stage his left hand was on the back of an officer on the other side of Mr Mataia; he then puts that hand on the cell bed behind him, while his right hand is placed on the shoulder of the other officer. Later both hands can be

[1] This is 1 minute and 33 seconds after they left S8. While the footage is from different cameras and I cant be sure their clocks coincide, this time frame seems reasonable

seen by his side. During this period this officer is seen to be more elevated than the others. Although he denied it, I am of the view he was kneeling on Mr Mataia's back, as he did in the S8 dayroom, and was using the cell bed and the other officer to maintain his balance.

Code Blue

A little more than two minutes after the group entered cell 5, the code blue was called and Mr Matai was rolled over into the recovery position after the other hand cuff was removed. The majority of the officers recalled him saying nothing throughout the whole struggle.

The CCTV footage shows they checked his pulse and seemed to clear his airway. The officers agreed they could find no pulse or respiration. They seem uncertain what to do next. They rolled him onto his back and then back into the recovery position. Finally they returned him to his back and commenced CPR.

They were still doing this when two nurses arrived at 10:46.16. The nurses spoke to the officers about the prisoner's condition but seemed reluctant to get involved in his care. About a minute later one of the nurses handed an air viva assisted breathing apparatus to one of the officers who, at the inquest, expressed disappointment that the nurse did not take over the CPR. He also said the air viva device came apart in his hands. The officers then return to using the laryngeal mask they had deployed before the nurses arrived. One of the nurses applied a pulse oxymeter to Mr Mataia's index finger which she believed confirmed what she'd been told by the officers about his having no pulse.

Sadly, the nurses had forgotten to bring a defibrillator. At 10:48.47, one of them left cell 5 and went back to the health centre to retrieve it. The officers kept rotating the giving of chest compressions. Three minutes after they had arrived at the cell, one of the nurses finally got down near the patient's head and examined him. She also assisted with exhaled air resuscitation for a brief period.

The nurses advised an officer to call for an ambulance. This call was made at 10:49am, some six minutes after the code blue was called.

The other nurse returned with the defibrillator and it was finally connected to Mr Mataia at 10:55.10. It showed Mr Mataia did not have a shockable rhythm and so it could not be used.

CPR continued until QAS officers arrived at 10.59. Those officers assessed the situation and at 11.20 advised that resuscitation attempts should cease and Mr Mataia was declared dead.

All officers left the cell and it was secured.

Preservation of evidence and officer welfare

The jail had been in "lock down" since soon after the code blue had been called. As lunch-time approached, the senior supervisor of the secure section, Mr Chris Jasperson, decided the prisoners should be let out of their cells for feeding because providing them with meals in their cells was far more labour intensive. However, letting them out required that all officers who had been involved in the incident return to their units. This occurred while attempts commenced to locate off duty officers to turn out to relieve them.

Police were called shortly after the death and numerous detectives and scenes of crime officers attended at the CCC soon after midday. The detectives took up with the General Manager, Mr Andrew Pike, and other senior officers. One of them advised Mr Pike that they would need to seize the uniforms worn by all CSOs involved in the incident. Arrangements were then commenced to find the officers spare uniforms to change into. This took some hours as a locker where some spare uniforms were supposed to be kept had apparently not been replenished and the officer with the key to the general store had to be called in. It seems further delay occurred because of a misguided belief that the uniforms had to be handed directly to a police officer.

As a result of these complications, the officers who had been involved in the incident were not segregated and their uniforms with blood and bodily fluids on them were not collected until some four or five hours after the incident; nor were they interviewed before this. Indeed two of the officers left the centre and declined to be interviewed at all. On the day of the incident, each provided a scant written report about the matter. It seems clear that two of those involved in the restraint of Mr Mataia colluded when compiling their reports.

This breakdown of the management of the incident had potential ramifications for the integrity of the investigation and the workplace health and safety of the officers. I shall return to it later in these findings.

Officers from the QPS CSIU attended at the centre the following morning and the investigation detailed earlier in these findings commenced.

The autopsy results

Dr Beng Ong, an experienced forensic pathologist, performed an external and full internal autopsy on the body of Mr Mataia on 20 October 2008. He found extensive bruising to numerous parts of the body. Of particular relevance were bruises found on both temporals muscles (muscles of the temple) with the left side more extensive; bruises on both sides of the head immediately behind the ramus of the jaw just below the ear canal; a bruise on the right base of the neck; bruises on the back of the left chest; bruises to the upper arms; and deep tram line like bruises to the wrists.

The most significant internal finding was a 75% occlusion of the left anterior descending coronary artery.

There was congestion to the face. The lungs had scattered areas of oedema and an occasional haemorrhage.

Although there was a small subarachnoid haemorrhage there was no underlying contusion.

Toxicology showed olazapine and sertraline, the drugs Mr Mataia had been prescribed for his mental illness. Dr Ong suggested both were above the therapeutic range, although for reasons I shall detail later I have discounted this.

After some brief discussion of the possibilities of the effects of the struggle and the restraint and a condition known as excited delirium, Dr Ong dismissed both and concluded that the cause of death was coronary atherosclerosis.

Conclusions as to cause of death

The submission by Queensland Health that there was no connection between Mr Mataia's mental illness and his death is misconceived in my view. Clearly, his mental illness was the main cause of his offending behaviour. The inability of health care professionals to stabilise his condition despite their prolonged and continuing efforts was a primary factor in Mr Mataia's aberrant behaviour that led to his incarceration. Had his Mental Health Act status been brought to the attention of the court at his last appearance it is likely he would have been transferred to an authorised mental health service where his treatment would have been different to that he received in prison. In my view therefore both his mental illness and the failure to detect the existence of the ITO did contribute to his death, although none of those involved in caring for or processing Mr Mataia through the court and correctional system could reasonably have foreseen this. I do not suggest they should be held responsible for his death.

I turn now to the direct, proximate and medical cause of his death.

In my view, in his autopsy report, Dr Ong gave inadequate consideration to the circumstances in which Mr Mataia died before he concluded coronary atherosclerosis was the primary cause of death. When he gave evidence at the inquest he was willing to concede that other possibilities were more likely. For example, he acknowledged the struggle in which Mr Mataia was engaged for 10 or 11 minutes before he collapsed is likely to have produced bio-chemical changes that could precipitate heart failure.

I accept Mr Mataia suffered from atherosclerotic occlusion in his right anterior descending artery of such severity that it left him susceptible to spontaneous interruption of blood flow and sudden death. However, in my view it would be unsound to rely solely on this susceptibility to explain the mechanism of death, while ignoring Mr Mataia's activities immediately preceding death. This was touched on by Dr Ong in his autopsy report when he noted:

> *"The potential of collapse would have been enhanced by the activities of the deceased prior to his death."*

Dr Ong explained this was a reference to the phenomenon referred to as "post exercise peril" which may be characterised by increased levels of catecholamines such as adrenaline and noradrenaline and a higher demand for oxygen. These changes, in the minutes after physical exertion are known to increase the risk of cardiac related death where the individual concerned is already compromised by a narrowed lumen in one or more of the coronary arteries.

Dr Ong also acknowledged the position in which Mr Mataia was restrained in cell 5 could compromise his respiration at a time when he needed more, not less, oxygen. He said he could not find any "*prominent*" signs of asphyxia, although he conceded the congestion found to Mr Mataia's face post mortem was one such. He acknowledged that artefacts usually associated with asphyxial deaths may not be present in restraint asphyxia cases. He also agreed the length of time between Mr Mataia being placed in a prone position in cell 5 and the discovery that he was not breathing was consistent with the time lapse one would expect in a case of restraint asphyxia. However, he said he dismissed restraint asphyxia as the primary cause of death because the restraint had ceased some time before Mr Mataia collapsed. That is not my view of the facts. Accordingly, I consider that possible cause needs further examination.

Counsel assisting helpfully tendered into evidence a chapter from a specialist autopsy text.[2] In the section dealing with restraint asphyxia, the initial sentence gives reason for caution;

> *The concept of restrain asphyxia as a distinct pathologic entity has not met with universal agreement, but sudden death occurring in the setting of restraint is a scenario not uncommonly encountered by most, if not all, forensic pathologist*.

Later in the same section the following appears:

> *The mechanism of death during prone positioning with violent resistance has been ascribed variously to positional asphyxia, mechanical asphyxia, and catecholamine induced cardiac rhythm disturbance. Much of the evidence appears to be circumstantial and intuitive and the matter is further complicated by the observation that some asphyxial deaths show little in the way the so called classic asphyxial signs; petetchia, cyanosis, congestion or oedema.*

The author highlights the danger of prone restraint is that it can entail interference with adequate chest expansion and pulmonary ventilation. He also notes "*one other factor in particular, truncal obesity or protuberant*

[2] Woodford NW, Injuries and death resulting from restraint, in Essentials of autopsy practice, Rutty GN (ed)

abdominal panniculus, may result in the splinting of the diaphragm in the prone position."

In a section starkly reminiscent of what occurred in this case the author notes:

> *Despite the conflicting physiological studies, intuition suggests it may not be unreasonable to postulate that extreme, prolonged physical exertion could result in a degree of hypoxemia, lactic acidosis, catecholamine surge and hyperkalemia to which restricted ventilation is added, resulting in a potentially lethal combination alone or in association with other factors such as cardio vascular disease.*

It was apparent that the prison officers involved in this matter had received no training in relation to positional asphyxia. I accept the evidence of those officers that they had not even heard of the term. That is an issue I shall return to later. It is also apparent that QCS has taken some action to remedy this deficiency and the training material they now use helpfully summarises the research the agency's training and policy section undertook about the issue. The material warns officers of "*a number of important factors commonly accepted as contributing to this phenomenon".* It then goes on to list them as follows:

> ***Psychosis*** *- Subjects displaying psychosis can go into oxygen debt very quickly when restraint positions prevent recovering such oxygen deficit, heart rhythm disturbances can occurring resulting in death;*
>
> ***Obesity*** *– subjects with large protruding stomachs or "beer bellies" are at risk from PA as the contents of the abdomen can be forced upwards in the abdominal chest cavity when the subject is in the prone position. This places pressure on the diaphragm thereby restricting respiration;*
>
> ***Diaphragm muscle fatigue*** *– this may occur after an intense period of physical activity i.e. a violent struggle. Such subjects may experience a lack of oxygen to working muscles and body tissues in general commonly referred to as hypoxia. Subjects may not present any clear symptoms of hypoxia to officers and simply stop breathing whilst being restrained;*
>
> ***Cardio vascular disease*** *– reduces lung capacity and blood flow which restricts the body's ability to exchange gases between the lungs and vessels; and*
>
> ***Multiple officers*** *– where several officers are required to hold a subject down in the prone position pressure can be placed on a person's ribcage restricting respiration.*

Later in the material, when explaining the development of positional asphyxia, the material describes the desperation of the subject as he continues to struggle in an attempt to breathe.

> *Responding officers may perceive this as a continued threat and apply even more force to restrain the subject. The subject, totally restrained in the prone position is unable to move and expends what energy they have left trying to inflate their chest in an attempt to breathe. It is at this point that the subject may become lethally exhausted and die. Even with immediate first aid the subject is rarely able to be resuscitated.*

It is likely Mr Mataia was undergoing some type of psychotic episode when the struggle commenced. His unreasoned attack on Mr Gee and his blank expression and silence throughout the ensuing struggle are consistent with his history of such episodes and support this conclusion.

He was undoubtedly obese and had extensive abdominal fat.

He engaged in a prolonged struggle with up to six officers. All say that he continued to struggle as he was moved from S8 to the DU. He was bent over from the waist with his hands cuffed behind his back when being moved; a position that no doubt hindered his capacity to recover from the oxygen debt he would have suffered after the initial struggle.

In the DU cell 5 he was held down by five officers, some of whom believed he was continuing to resist them and who accordingly continued to exert downward pressure on his back and legs. For the reasons detailed earlier, I conclude these efforts included one officer kneeling in the middle of Mr Mataia's back. The resultant bruises support this conclusion. Dr Ong agreed the ability of Mr Mataia to meet increased oxygen demand would be inversely proportional to the amount of downward pressure placed on him during the period of restraint.

When placed in the prone position, with hands secured behind the back and with downward pressure from the CSO's restraining him, Mr Mataia's body shape would have contributed to a restriction in oxygen intake. Even though the airway remains clear, it is recognised that such situations can lead to "splinting" of the diaphragm; reducing the capacity of the lungs on inspiration.

Mr Mataia's struggle at this stage was equally explicable as a vain attempt to breathe. He was in the position for about two minutes before it was noticed he had stopped breathing and the restraint was released.

The literature recognises ascribing a single, neat cause of death to situations such as that involving Mr Mataia is extremely difficult and likely inappropriate.[3]

[3] Woodward, NWF *Injuries and Death Resulting from Restraint,* "Essentials of Autopsy Practice", Springer, 185

In my view it is likely the manner in which Mr Mataia was restrained combined with the violent prolonged struggle and his underlying heart disease caused his death.

In his autopsy report Dr Ong noted sertraline toxicity to be a significant background condition related to the death. This was based on toxicology analysis showing a level of 0.5mg/kg. Sertraline is a drug found in the anti-depressant medication Zoloft which had been prescribed to Mr Mataia by medical staff at the CCC. Counsel assisting caused this result to be reviewed by Dr Olaf Drummer a specialist toxicologist. He reported:

> *In post-mortem environments there is diffusion of drug from tissue sites to pooled blood. This often causes an elevation of blood concentrations since tissue concentrations are often higher than the blood concentration. This is known as post-mortem redistribution. In the case of sertraline it is known to undergo elevations in blood concentration postmortem. A concentration of 0.5 mg/kg would, in my view still be consistent with "therapeutic use", i.e. concentrations from prescribed doses. This means that the actual concentration at the time of his death is likely to have been lower, and probably much lower than the 0.5 mg/kg.*

Having regard to that evidence, I conclude the sertraline levels found at autopsy were consistent with therapeutic levels during life. Although it can increase the propensity of the heart to undergo dysrhythmia, sertraline is unlikely to have contributed to Mr Mataia's death.

Findings required by s45

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

Identity of the deceased – The dead man was Tofia Josen Mataia.

How he died - Mr Mataia died after he assaulted two prison officers and a lengthy struggle ensued, as five other officers, who were not aware of the dangers of restraint asphyxia, sought to restrain him, move him to a detention unit and then pinned him to the floor for some minutes.

Place of death – He died while in custody at Capricornia Correctional Centre at Rockhampton in Queensland.

Date of death – He died on 18 October 2008.

Cause of death – Cardiac arrest as a result of the combined effects of severe coronary atherosclerosis, obesity, schizophrenia, a violent struggle and prone restraint.

Referral to DPP

The Coroners Act, in s48, requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence"* to give the information to the appropriate prosecuting authority.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard. That would include the evidence necessary to rebut any defence reasonably raised by the evidence. The facts of this case require I consider whether the information gathered during the investigation and inquest should be referred to the DPP to enable him to determine whether any of the CSOs should be prosecuted for unlawfully killing Mr Mataia.

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 293 of the Code states that. "… *any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person."*

Section 300 of the Code states that, *"Any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case."*

> In *R v Carter* [4] the Court of Appeal examined the issue of causation as it arises in Section 293 in cases where there may be no single cause of death. The court adopted the reasoning of Dean and Dawson JJ in *Royall v The Queen:-*
>
> *"… if the accused's conduct is a substantial or significant cause of death that will be sufficient given the requisite intent, to sustain a conviction for murder. It is for the jury to determine whether the connexion between the conduct of the accused and the death of the deceased was sufficient to attribute causal responsibility to the accused."*[5]

In *Royall,* Toohey and Gaudron JJ noted that the jury must be told that they need to reach a conclusion as to what caused the death but stated:

[4] [2003] QCA 515

[5] *1991) 172 CLR 378* at *423*

> "*That does not mean that the jury must be able to isolate a single cause of death; there may be more than one such cause … In that event it is inevitable that the jury will concentrate their attention on whether an act of the accused substantially contributed to the death."*

In *Carter,* McPherson JA considered that the use of the words 'substantial' and 'significant' in the above passages were made in the context of their being synonyms.

In order to prove the elements of an offence in the present case, it would be necessary to establish that:-

- the application of force by one or more CSO's was a substantial or significant cause of his death; and
- the killing was not justified, authorised or excused by law.

I have found it is more likely than not that the force used by the CSOs contributed to the death. I can not quantify the extent of that contribution but it may have been substantial or significant. However, I have made that finding on the civil standard. It is less clear that a jury could be so satisfied beyond reasonable doubt.

Further, I accept that the CSOs did not intend to cause serious harm to Mr Mataia and that his death would not have been reasonably foreseeable by a person with their limited and inadequate training. As a result, the Crown could not rebut the defence of accident set out in s23 of the Code. Accordingly, I do not intend to refer the material to the DPP.

Referral to the Nursing & Midwifery Board

The Act provides in section 48(4) that a Coroner may give information about a person's conduct to a disciplinary body for the person's profession if the Coroner believes the information might cause the organisation to take steps in relation to the conduct.

As of 1 July 2010 the Nursing and Midwifery Board of Australia is the body appointed to consider complaints and notifications about the conduct of medical professionals in Queensland.

The *Health Practitioner National Law Act 2009* (Qld) ("HPNLA") sets out the grounds on which voluntary notification can be made to the Board in section 144. These include:

> *(a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;*

> *(b) that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;*

The HPNLA confers powers on the Board to investigate and commence disciplinary proceedings as a result of a notification.

There were aspects of the response to the code blue which are concerning.

The failure of the nurses to conduct a formal clinical assessment of Mr Mataia on their arrival was inappropriate. It was not reasonable to rely on the CSOs' assessment that Mr Mataia had no pulse for example and I do not accept they could have seen that his pupils were fixed and dilated when they were standing some distance from him. It may well be they were correct in their assessment that Mr Mataia was already dead and that may explain the laxity of their response but it does not excuse it.

One of the nurses should have immediately got down near the patient and reviewed and recorded his vital signs.

The nurses should also have taken a more active role in managing the resuscitation attempt. The CCTV footage shows the CSOs undertaking fairly disorganised and unprofessional CPR. The nurses were content to allow this to continue, although I accept their evidence they gave words of encouragement and advice. That was inadequate in my view. They were the health professionals: they should have taken control and ensured strict adherence to CPR protocols.

It is also of concern that some 11 to 12 minutes elapsed between the calling of the code blue and the use of a defibrillator to check Mr Mataia's heart rhythm, primarily because the nurses forgot to bring one with them. The report of Dr Dooris cited statistics to support the conclusion that:

> *The delay in access to defibrillation has* (sic) *an important impact on Mr Mataia's probability of survival.*

That conclusion is to some extent purely theoretical because the use of a defibrillator would only have been of assistance had Mr Mataia a shockable rhythm. By the time the device was attached to him that was not the case and there is no evidence concerning when that state was reached.

Research literature indicates survival after an asystolic arrest is very rare. Indeed a review of 9505 patients in Western Australia who had suffered an out of hospital cardiac arrest found that none of those who were in asystole when paramedics arrived survived.[6]

[6] Symonds A, Is the Treatment and Transport of Asystolic Cardiac Arrest Patients to Hospital by Ambulance Services Appropriate? Thesis for MSC Edith Cowan University, http://adt.ecu.edu.au/adt-public/adt-ECU2007.0031/01front_SymonsA.pdf

In this case it is impossible to determine whether Mr Mataia would have survived had a defibrillator been available when the nurses first arrived in the cell, but the absence of any detectable pulse soon after his collapse counts against it.

In my view the Nursing and Midwifery Board of Australia could conclude that the conduct of the nurses established a basis for notification, and subsequent investigation, under s.144 of the HPNLA.

However, the disciplinary regime created by the HPNLA is not punitive in focus: rather it is designed to maintain public confidence in the medical profession and maintain professional standards.

I accept Counsel Assisting's submission that Ms Pauline Gallie showed insight into the shortcomings exposed by this incident. She acknowledged that she should have done better. It is also clear that, in part, her failing to provide prompt care to Mr Mataia was a product of inadequate training and poor equipment.

Accordingly, I conclude it would not be in the public interest for me to make a referral to the Nursing and Midwifery Board of Australia in relation to her conduct. Her colleague, Judy Gallie, was absent for most of the period when action should have been taken as she went to retrieve the defibrillator. For that reason I do not intend to refer her conduct to the Board either.

Comments and recommendations

Section 46 provides that a Coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. That requires the coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

In this case a number of issues warrant consideration from that perspective, they include:

- the apparent failure of the authorities to recognise that when Mr Mataia came into custody on the last occasion he was the subject of a current ITO;

- the apparent failure of prison authorities to cause any mental health assessment to be undertaken until nine days after he came into custody;

- the apparent failure of prison authorities to manage his seclusion and release into the general prison population in accordance with relevant policies and legislation;

- the apparent failure of prison mental health staff to access Mr Mataia's mental health records from the Cairns Mental Health Service;

- the apparent failure of CCC mental health staff to alert QCS staff to aspects of his mental health history relevant to his management;

- the apparent failure of QCS staff to ensure all CSOs dealing with Mr Mataia were aware of the special danger he posed;

- the apparent failure of QCS to adequately train CSOs in the dangers of restraint asphyxia and the need to monitor prisoners' health during extended restraint;

- the apparent failure of Queensland Health to ensure the nurses at the CCC were adequately trained in the use of their equipment;

- the apparent failure of QCS to ensure its policies provided for the immediate calling of an ambulance when a medical emergency was discovered; and

- the apparent failure of the CCC senior managers to adequately ensure QCS policies concerning scene and evidence preservation were adhered to.

It is important to acknowledge that most of these perceived deficiencies have been addressed by recent reforms. QCS and Queensland Health are to be commended for the extensive changes that have been made since this death occurred. Where reforms do not seem to have been made, I have made recommendations for improvements.

It is also important to acknowledge that Mr Mataia's mental illness and personality disorders made him an extremely difficult patient/prisoner to manage. His tendency to abuse illicit drugs and his failure to comply with medication regimes compounded his lack of insight into his illness. The medical records indicate none of the health services he dealt with over a number of years succeeded in stabilising him for any extended period.

That means that even if the deficiencies I outline below had not existed, the outcome may well have been the same. However, it does not excuse or explain those deficiencies.

Identification of persons subject to an ITO

Mr Mataia should not have been sent to the LGCC, and later CCC, after he was arrested on 18 August 2008 and remanded in custody the following day without due consideration being given to his status under the Mental Health Act.

Chapter 3 of the *Mental Health Act 2000* enables a person in custody or before a court to be transferred to an authorised mental health service for

inpatient care. These provisions may be applied to a person on an existing ITO. There was a failure by police, by court staff, by QCS officers at LGCC and ultimately by QCS staff and treating psychiatrists at CCC to identify that Mr Mataia was the subject of an ITO.

Indeed it seems at no stage throughout the eight weeks Mr Mataia was in custody did anybody think to get his medical records from the Cairns Mental Health Unit.

It seems likely this was not an isolated incident as the director of Mental Health, Dr Aaron Groves, indicated very significant work has been undertaken to prevent this happening. He explained the adoption of the Consumer Integrated Mental Health Application (CIMHA) allows access to state-wide mental health clinical information. It is manually cross-referenced in 31 Magistrates Courts with the daily court list in order to identify involuntary patients.

The CIMHA system, if made available to mental health staff operating in Queensland prisons, would also provide a safeguard for circumstances where the initial cross-checking procedure fails. Currently CIMHA is not available within correctional facilities although apparently negotiations between Queensland Health and the Department of Community Safety on the issue are well advanced. This is an important reform that should be pursued urgently.

In the circumstances, no recommendation by me is necessary in relation to this issue.

QCS staff access to prisoners' medical information

Some of the CSO's dealing with Mr Mataia were not aware of his mental health history, nor were all aware of his propensity for unprovoked violence. It is not clear why this occurred as policies did exist for the sharing of "general information" between Queensland Health and QCS that was relevant to the management of prisoners. Clearly these policies had not been implemented at the CCC at the time of Mr Mataia's incarceration there.

Ms Shannon Tracey, a psychologist employed by the Central Queensland Mental Health Service as the District Forensic Liaison Officer, described in her statement the implementation of case conference meetings at CCC. These meetings include staff employed by QCS, such as counsellors, psychologists, cultural liaison officers and sentence management staff, along with nurses from Offender Health Services and the CCC mental health worker.

Information regarding propensity for violence and the link this may have with a refusal to take medication or a change in the dose or type of medication is shared at these meetings.

I accept these meetings can achieve an appropriate balance between a prisoner's right to privacy and the need for those managing the prisoner to

have access to information about the prisoner's health that is likely to impact upon their behaviour. No further comment by me is required.

Release into the general prison population

When Mr Mataia was transferred to the CCC he was on a Safety Order which justified his seclusion in the DU. Another order was made on 28 August 2008 that authorised his continued isolation until 25 September. However, the next day, Mark Nelson directed he be moved out of the DU. This was done even though the order was not cancelled until 8 September. I am of the view Mr Nelson was not authorised to cancel the order. Further, in my view there was inadequate consideration given to Mr Mataia's future management when he was peremptorily released into the general prison population.

The QCS policy governing Safety Orders mandated that an Intensive Management Plan (IMP) "*should*" have been created at the conclusion of the Safety Order. This was not done. Senior QCS staff seem to interpret this policy differently from the Chief Inspectors investigators and myself but could point to no evidence to indicate that the need for an IMP was even considered in this case.

Recommendation 1 – Safety Orders and IMPs

I recommend QCS ensure all senior managers are aware of the limited number of officers authorised to make and cancel Safety Orders and of the requirement that upon the cancellation of such an order consideration be given to the need to make an Intensive Management Plan .

Dissemination of information about prisoners

At the time of Mr Mataia's death, there was a procedure in place at the CCC to enable information regarding problematic prisoners to be disseminated to CSOs. However, it was acknowledged at the inquest that the system did not ensure briefings were repeated often enough to ensure all rostered staff became aware of relevant issues.

Since the death of Mr Mataia a system has been adopted whereby prisoners previously on an IMP continue to be identified by way of clear markings on their file even after the IMP has ceased.

Further, the QCS Integrated Offender Management System (IOMS) has been modified to ensure such information is on the front page of a prisoner's record and easily observable. The intranet system for CCC provides for easy access to a list of prisoners identified as being problematic. This reduces the reliance on morning briefings to CSO's (which continue) and on the other system in place at the time of Mr Mataia's death in which CSO's were required to search, without any particular priority, through the computer records of several prisoners under their care each day.

I am satisfied the systems in place at CCC for the dissemination of information to CSO's have been greatly improved and are now adequate.

Training of CSO's in restraint techniques

It is alarming that at the time of Mr Mataia's death there was widespread ignorance among CSOs of the dangers of restraint asphyxia. This was directly attributable to inadequate training, an inexplicable deficiency in the 21st century. I have concluded this mechanism contributed to the death and it is clear that none of those involved in the incident sufficiently monitored the prisoner's condition as events played out.

There have been significant developments in the attention given to the issue in CSO training material as the excerpts I quoted earlier demonstrate and it seems the practical training since the death of Mr Mataia has also focussed on the risk of restraint asphyxia. All the officers who gave evidence at the inquest and who continue to be employed by QCS have now received the updated training. This is consistent with the evidence of Ms Morison that this is the case for well over 90% of CCC staff.

The new policy stipulates if any of the restraint asphyxia risk factors are present attempts should be made to avoid prone restraint. It could be argued the need to avoid restraining prisoners while holding them in a prone position is not sufficiently stressed. However, I accept QCS has a primary responsibility to ensure the safety of its staff and I do not have sufficient evidence to articulate how that could be better managed while further reducing the risk posed by prone restraint.

Therefore in my view the content of the training materials is adequate and appropriate.

Similarly, changes made to restraint and control training that allow for the walking of restrained prisoners backwards only when other options cannot be used and that provide for the regular checking of the prisoner's condition during breaks in the process are also commendable.

No further comment by me is needed in relation to this issue.

Medical facilities and training

I accept the nurses arrived at the DU without a defibrillator because the then recent procurement of new machines had caused it to be moved from the emergency trolley, although it is difficult to understand why neither nurse noticed its absence as they made their way to the cell.

It also became apparent the nurses had not received any training in the use of the new machine. This reflects poorly on those responsible for managing health services in the CCC.

As indicated earlier, while I can not be sure, it seems likely Mr Mataia had suffered an asystolic arrest before the code blue was called and accordingly his survival chances were very slight even if everything had been done to the highest standard.

I accept that the equipment issues that led to sub-standard care being provided to Mr Mataia have been adequately addressed. In particular this concerns the provision of new Life-Pak machines and Air-Viva devices. Plans to station a Life-Pak machine in the DU should be expedited, as should training of staff in the machine's use.

Training standards of nursing staff at CCC have clearly improved. At the time of Mr Mataia's death nurse Pauline Gallie had not updated her CPR training with the requisite regularity. Nursing staff at CCC now have access to "in house" training.

It seems the policy of the CCC and perhaps other correctional centres is for a nurse to examine a prisoner before an ambulance is called. This can result in unnecessary delay in my view. Untrained members of the public frequently call QAS of their own volition and lives are saved as a result. This case is a good example of those where any reasonable person would realise an ambulance was needed. Medical evidence overwhelmingly demonstrates that the most critical aspect determining survival after a cardiac arrest is the time between the arrest and the provision of emergency care.

Recommendation 2 – CSOs to call QAS

In my view whenever an employee of a correctional centre has reason to believe a medical emergency exists, he or she should be required to call the QAS without waiting for a nurse from the health centre to come and examine the prisoner. I recommend that the Commissioner of Corrective Services cause all correctional centres to amend their policies accordingly.

Preservation of crime scenes and evidence

It is apparent the managers at the CCC did not appreciate all of the steps needed to preserve the integrity of the investigation of Mr Mataia's death even though they are articulated in QCS policy. This led to a failure to isolate the witnesses until they could be interviewed and seize their clothing before evidence on it could be contaminated**.**

Further, it seems the CCC had no local contingency plan in place as was required. These have since been developed and place worthy emphasis on staff welfare, but still do not draw sufficient attention to the issue of the preservation of evidence. The evidence of the former General Manager who now occupies the equivalent position in Townsville indicates these limitations may not be restricted to the CCC.

The QCS submission suggests training in relation to crime scene management and the preservation of evidence is provided to agency staff throughout the state. It appears from the facts of this case and the evidence of Mr Pike that this training has been inadequately implemented in some regional correctional centres.

Recommendation 3 – Scene and evidence preservation

In view of the evidence that regional correctional centres such as Capricornia and Townsville have limited procedures in place to ensure the integrity of a death in custody investigation is not compromised by the initial response of officers at the scene, I recommend the Queensland Corrective Services Commissioner seeks the assistance of the CSIU to review existing policies at all correctional centres and where necessary assist in the provision of training to CSOs.

Power to compel answers of relevant persons

The *Corrective Services Act* empowers inspectors appointed under that Act to require CSO's to provide information regarding an incident in a correctional facility. However, in practice inspectors usually postpone their investigation until the CSIU has interviewed all witnesses. The CSIU officers have no power to require QCS staff to provide information about any incident, even a death. A Coroner can issue a notice requiring any person to provide information relevant to an investigation but that process necessarily involves delay and the subject of such a requirement can lawfully refuse to comply if to do so might incriminate the witness.

In this case two of the CSOs involved in the restraint of Mr Mataia declined to be interviewed by the CSIU investigators and supplied only scant information in self serving reports.

Recommendation 4 – Obligation to provide information

Prisons can be dangerous places. The public has an abiding interest in ensuring they are managed as safely as possible and that the actions of those in charge of them can be effectively scrutinised. Neither prison officers nor prisoners should be able to decline to assist police officers investigating a death in prison. Accordingly, I recommend the Commissioner of Corrective Services considers seeking to have the Corrective Services Act amended to require any person suspected of having information about a death in a correctional centre to provide that information to CSIU officers with the proviso that any information provided can not be used against them in criminal or disciplinary proceedings.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
9 July 2010