QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Nathan David McGrath** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Cairns |
| FILE NO(s): | COR 2012/2174 |
| DELIVERED ON: | 17 April 2014 |
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| HEARING DATE(s): | 7 March; 31 March – 1 April 2014 |
| FINDINGS OF: | Mr Terry Ryan, State Coroner |
| CATCHWORDS: | CORONERS: Death in custody, drug overdose, unclothed searches of prisoners |

REPRESENTATION:

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| Counsel Assisting: | Miss Emily Cooper |
| Queensland Police Commissioner: | Ms Belinda Wadley (QPS Solicitors Office) |
| Constable David Coffey, Senior Constable Jennifer Noble, Sergeant Colin Thomas, Sergeant Malcolm Meadows: | Mr Calvin Gnech (QPU Legal Group) |

The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Nathan McGrath. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

# Introduction

At the time of his death, Nathan David McGrath, 35, was being held at the Cairns Watchhouse (CWH). Late on the afternoon on 24 June 2012, he was arrested due to two outstanding warrants, one of which was for trafficking in drugs in the state of Victoria. A pat down search was conducted in preparation for him to enter a cell. Nothing was located during this search. A small amount of amphetamine and a significant quantity of cash were located in his wallet. These items were seized and Mr McGrath was also arrested with respect to the possession of drugs.

Later that night, Mr McGrath was noted to be acting erratically. He was observed by watchhouse staff on the CCTV monitor for some minutes before a police officer attended his cell. His cell mate was removed from the cell. The Queensland Ambulance Service (QAS) was contacted and attended. It was decided that Mr McGrath would have to be sedated before treatment could commence. Mr McGrath stopped breathing while preparatory measures relating to the sedation were occurring. The cell was opened and resuscitation commenced. It continued en route to Cairns Base Hospital (CBH) but was unsuccessful. Mr McGrath was subsequently pronounced deceased at 2:54am on 25 June 2012.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death

- consider whether an unclothed search should have been conducted in preparation for Mr McGrath being detained at the CWH on 24 June 2012

- consider the adequacy of the current training of CWH staff relating to the QPS guidelines for searching prisoners

- consider if there are ways to prevent a similar death occurring in the future, in particular, whether any changes need to be made to the current police guidelines relating to unclothed searches.

## The investigation

An investigation into the circumstances leading to the death of Mr McGrath was conducted by Acting Detective Inspector Cameron Herpich from the Queensland Police Service (QPS) Ethical Standards Command (ESC).

Upon being notified of Mr McGrath's death, the ESC attended and an investigation ensued. The investigation was informed by statements and recorded interviews with the relevant watchhouse officers and police officers, fellow inmates, QAS staff, the emergency doctor at CBH, other associates of Mr McGrath and his next of kin. CCTV footage and documentation relating to policies and procedures at CWH were also obtained. Forensic analysis was conducted. The entirety of the police investigation material was tendered at the inquest.

A full internal autopsy examination was conducted by Senior Staff Specialist Forensic Pathologist, Paull Botterill. Further photographs were taken during this examination.

In his capacity as the QAS Medical Director, Dr Stephen Rashford conducted a review of the decisions made by the QAS officers. That review was provided to assist the investigation with examining the adequacy of the medical intervention provided to Mr McGrath.

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

## The Inquest

An inquest was held in Cairns on 31 March 2014 – 1 April 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Miss Cooper, proposed that all evidence be tendered and that oral evidence be heard from the following witnesses:

- Acting Detective Inspector Cameron Herpich
- Senior Sergeant Peter Deasy (Officer in Charge at the relevant time, CWH)
- Constable David Coffey (Arresting Officer)
- Constable Stuart Rainbow (Watchhouse Officer, CWH)
- Sergeant Malcolm Meadows (Watchhouse Manager, CWH)
- A/Sergeant Jennifer Noble (Watchhouse Manager, CWH)
- A/Sgt Colin Thomas (Watchhouse Manager, CWH)
- Senior Sergeant Paul Gardiner (Current Officer in Charge, CWH).

I agreed that the evidence tendered in addition to the proposed oral evidence was sufficient for me to make the requisite findings.

# The evidence

## *Personal circumstances and correctional history*

Nathan McGrath was born in Kerang, Victoria on 20 July 1976. His mother, father and brother all reside in Victoria. His sister resides in Canada. Mr McGrath maintained weekly contact with his parents. In the lead up to his death, he had advised his family that he intended to get work in the mining industry. He had reportedly used marijuana since he was aged 15 years. However, it was only in recent years that he had started using heroin and other illicit drugs. Information provided to the inquest by Mr McGrath's ex-girlfriend indicates that he was using drugs every day.

Mr McGrath's criminal history in Victoria began in 1994. Over the years he was convicted for drug related offences including possession and trafficking; assault related offences including assaulting police; possessing stolen goods and various breaches of court orders. He had previously spent time in custody.

Mr McGrath's detention at the CWH on the afternoon of 24 June 2012 was due to two outstanding warrants, one for trafficking drugs in Victoria and the other for assault occasioning bodily harm in Queensland. Further, he had been charged with possessing dangerous drugs with respect to a quantity of methylamphetamine located in his wallet following his arrest.

## *Medical history*

The information relating to Mr McGrath's medical history was provided by his father, Bruce McGrath. He confirmed that about 12 months before his death, Mr McGrath had been treated for testicular cancer in Victoria. He had undergone surgery and also underwent chemotherapy. He also had Hepatitis C.

With respect to his long standing drug use, Mr McGrath was known to display episodes of aggression and rage when he was using drugs. He was never diagnosed or treated for any mental disorders.

In the lead up to his detention at CWH, Mr McGrath was not receiving any ongoing medical treatment.

## *Events leading to death*

Just after 5pm on Sunday 24 June 2012, Mr McGrath presented to the Cairns Police Station seeking assistance with leaving his current share accommodation. He informed Constable David Coffey that he was having difficulties with his housemates and feared he may be assaulted. He was provided with the phone number for Policelink and advised that should he have difficulties with his housemates he should call that number and police would attend at the house.

Constable Coffey's evidence was that Mr McGrath was pleasant and polite. Mr McGrath was happy with this advice and left the station to call the number.

At this point, Constable Coffey conducted some initial police checks with respect to Mr McGrath by searching the CrimTrac database. This database enables police to share information with each other across state and territory borders. Constable Coffey found that there were outstanding warrants for trafficking drugs (Victoria) and assault occasioning bodily harm (Queensland).

About 20 minutes after leaving, Mr McGrath returned to the station because his phone was not working thus not allowing him to call Policelink. Constable Coffey asked for his drivers licence so that identity could be confirmed. This was done, after which Constable Coffey informed Mr McGrath of the outstanding warrants and that he would be required to be taken into custody.

It seems that although Mr McGrath was unaware of the outstanding warrants he was cooperative with police. He was escorted to the watchhouse by Constable Coffey and another officer. Constable Coffey informed the watchhouse supervisor, A/Sgt Jennifer Noble of the outstanding warrants identified in his searches.

A property search was conducted by civilian watchhouse officer Lorraine Van Dulken. A small clip seal bag containing 0.18g of amphetamine was located in Mr McGrath's wallet. He claimed to have no knowledge of it and said that it must have been put there by his housemates. A total of $997.80 in cash was also located in the wallet. These items were seized and Mr McGrath was arrested with respect to the possession of drugs.

A pat down search was then conducted by watchhouse officer Constable Stuart Rainbow, who also scanned Mr McGrath with a metal wand. No items of interest were located at this time. An unclothed search was not conducted. Mr McGrath was taken to cell M-10 which already accommodated another male, Ashley Gibson. Cell checks were conducted hourly throughout the night with no issues reported.

At about 11:30pm a prisoner in cell M-8, Eddie Pootchemunka, used the cell intercom to contact watchhouse staff. Mr Gibson had asked him to do this because Mr McGrath was acting erratically and Mr Gibson was starting to experience chest pains. Mr McGrath's behaviour was monitored for a few minutes on the CCTV before A/Sgt Colin Thomas proceeded to the cell to extract Mr Gibson and to try and get Mr McGrath to calm down. It was thought at this stage that Mr McGrath may have been experiencing a psychotic episode. A/Sgt Thomas' attempts at getting Mr McGrath to calm down seemed to work for a short time.

At 11:36pm the QAS was called to attend both Mr Gibson and Mr McGrath. A unit of one Advanced Care Paramedic (ACP), Jeremy Lawrence, arrived at 11:44pm. He attended to Mr Gibson given that his chest pains were categorised as a more serious threat than Mr McGrath's erratic behaviour.

A second unit of two ACPs, Celina O'Leary and William Papashalis, arrived at the watchhouse at 11:51pm. They were taken to Mr McGrath's cell which had remained locked given the risk he presented to officer safety. The ACPs

assessed him by looking through the Perspex window. It was decided that he would need to be sedated before he could be treated. The ACPs did not have the skills to do this, so Papashalis made a phone call to the QAS Medical Director Dr Stephen Rashford to request an Intensive Care Paramedic (ICP). The call took place at midnight.

Papashalis was informed that the only ICP in the area that night was on a helicopter to another job. Papashalis commenced getting advice from Dr Rashford, but approximately four minutes into the call it became apparent that Mr McGrath had stopped breathing. The cell was opened and both ACPs commenced resuscitation with the assistance of the watchhouse officers. This continued en route to CBH.

Mr McGrath arrived at CBH at 12:23am but was unresponsive. He was assessed as being in cardio-respiratory arrest by Emergency Department Dr Digby Green. Chest compression was started immediately and ventilation was taken over by emergency staff. Adrenaline and fluid were administered and CPR continued. Mr McGrath's heartbeat returned but the prognosis was very poor. His extremities showed no blood circulation, his heart was dependant on adrenaline and there was no attempt to breathe spontaneously. The decision was made to withdraw treatment and Mr McGrath died shortly after at 2:54am.

## *Autopsy results*

External and full internal examinations were conducted by Senior Staff Specialist Forensic Pathologist Paull Botterill on 25 June 2012.

External examination identified multiple abrasions and bruises over the hands and legs. Internal examination showed single vessel coronary artery atheroma with greater than 60% narrowing. There was no associated myocardial scarring.

Blood samples from the femur revealed a relatively low range of amphetamine (0.35mg/kg) and a potentially lethal range of methylamphetamine (9.9mg/kg). Very small levels of cannabis and Midazolam (a benzodiazepine) were also present.

The cause of death at the time of the autopsy was not clear. The possibilities considered by Dr Botterill were excited delirium syndrome, amphetamine and/or other drug toxicity and coronary artery atheroma. Given these possibilities microscopic examination was then performed.

Microscopic examination showed lung congestion, changes of probable fat and/or air embolism (most probably due to resuscitative efforts), lung and skin changes consistent with past and recent intravenous access and liver changes in keeping with past viral hepatitis. There were no kidney or muscle changes that are sometimes seen with life-threatening elevations of body temperature.

Dr Botterill opined that although the methylamphetamine levels were reported in the potentially lethal range, there is only limited correlation between blood levels and the clinical effects in any given individual. There is known to be considerable overlap between blood levels seen in living habitual users and those subjects who died from methylamphetamine toxicity. Despite this, the blood level in Mr McGrath was very high, and as the underlying natural heart disease present was less marked than that usually associated with sudden unexpected death, methylamphetamine toxicity appeared to be the most likely cause of death. This is particularly so given the state of his behaviour prior to the clinical arrest, and the hospital clinical observations strongly suggest a hyperactive, hyperthermic state.

The direct cause of death was determined as methylamphetamine toxicity. Coronary artery atheroma was determined to be a significant contributor to the death.

## *Investigation findings*

None of the other inmates at the CWH provided information to the investigating officer suggesting foul play or that there was any deficiency or inappropriateness in the treatment received by Mr McGrath while detained in custody.

The examination of Mr McGrath's body and his cell at CWH revealed no signs of violence.

The investigation identified that Mr McGrath did not appear to be affected by drugs or alcohol at the time of his arrest. That fact, coupled with the findings at autopsy, led investigating police to the ultimate conclusion that Mr McGrath must have had a further amount of methylamphetamine somewhere on his person which was not detected during the pat down search. Mr McGrath was then able to take the drugs into the cell, and ingest them later in the evening which then brought about his agitated and erratic state and ultimately led to his death.

Investigating police made the following conclusions:

- It was reasonable to assume that, had an unclothed search been conducted, the drugs may have been located on Mr McGrath's person.
- The level and timeliness of the medical intervention was both timely and appropriate.
- There was no evidence implicating any other person as being directly involved in the death.
- There was no misconduct or breach of discipline by police associated with Mr McGrath prior to his death.

Investigating police included the following recommendations in their report:

- The QPS review the current strip search policy of persons entering into custody at the watchhouse.

- The current draft review of the policy concerning medical interventions within watchhouses is further considered to ensure best practice procedures are utilised by the QPS.

## *Unclothed searches*

Section 629 of the *Police Powers and Responsibilities Act 2000* (PPRA) provides that a police officer conducting a lawful search of a person may require the person to remove all items of clothing, or all items of outer clothing from the upper or lower part of the body. Section 630 of the PPRA contains a number of safeguards aimed to protect the dignity of the person being searched.

The PPRA provisions were enacted following the 2000 Report of the Criminal Justice Commission (CJC) *Police Strip Searches in Queensland an Inquiry into the Law and Practice.* The CJC's report contained a statement of principles that are reflected in both the PPRA and s.16.10 of the QPS Operational Procedures Manual (OPM).

- A person's physical integrity is a fundamental right that should be respected even in situations where the person is in custody. A strip search is an affront to a person's physical integrity. A person should not be subjected to a strip search without a justifiable reason.
- Given the intrusiveness of the police power to conduct strip searches, there needs to be strict accountability processes.
- Policies and procedures relating to strip searches need to be simple, practical and consistent.
- QPS officers are entitled to clear guidance on when and how to conduct strip searches.
- Recommendations requiring legislative amendments should be kept to a minimum to facilitate early implementation and future adjustments. The Police Responsibilities Code and the QPS Operational Procedures Manual will generally be easier to amend than the Police Powers and Responsibilities Act.
- At all times a watchhouse manager's principal concern must be the health and safety of all people in the watchhouse.

Section 16.10 of the OPM provides that, in addition to the requirements of the OPM, a police officer's or watchhouse officer's approach to searching persons is to be based upon the following general principles:

(i) a person's physical integrity is a fundamental right that is to be respected even when the person is in custody;
(ii) being subjected to a personal search by a police officer or watchhouse officer, in particular a search involving the removal of clothing, is a traumatic and degrading experience for most people;
(iii) whilst the Police Powers and Responsibilities Act allows a police officer or watchhouse officer to require someone to remove clothing when the person is being searched, and that circumstances which justify such a search may arise from time to time, searches involving the removal of clothing are not to be conducted as a matter of routine; and

(iv) searches that involve the removal of clothing which are not appropriately conducted may invite adverse criticism of the Police Service.

The OPM confirms that the overall management of persons in the watchhouse is up to the watchhouse manager (s.16.12). The watchhouse manager can give a person in custody at the watchhouse any reasonably necessary directions, or take any reasonably necessary steps for ensuring the good management and control of the watchhouse.

It is clear from the evidence that, upon a person being arrested and then detained at the watchhouse, a property search and pat down search are standard searches to be conducted on all persons regardless of the circumstances. There is no set position as to who is to conduct these searches. Sometimes the arresting officer will conduct the searches, and at other times they will be conducted by civilian watchhouse officers or by the police officers stationed at the watchhouse.

Unclothed searches (also referred to as strip searches) must be authorised by the responsible officer, or the relevant watchhouse manager on shift (s.16.10.2). It is a matter of broad discretion as to whether a strip search is conducted. The OPM makes it clear that before ordering an unclothed search the watchhouse manager must hold a reasonable suspicion that the person to be detained has something secreted on their person which may place themselves or other detainees at risk.

The general considerations to assist watchhouse managers in determining whether to conduct an unclothed search are taken from s.16.10.2 of the OPM and include:

- Previous or present threat of suicide or self harm;
- Previous violence;
- Previous instances/attempts of concealing contraband in custody;
- Intravenous illicit drug history;
- Previous escapes or attempts or threats of escape; and
- Criminal history.

Other factors, such as the circumstances surrounding the offence with which the person is charged and the general demeanour of the person (i.e. whether or not they appear drug affected or intoxicated), are also to be given consideration.

Mr McGrath's arresting officer, Constable David Coffey, did not conduct either the property search or the pat down search. Both searches were conducted by separate watchhouse officers, namely Lorraine Van Dulken (civilian) and Constable Stuart Rainbow. Constable Coffey's evidence was that while these searches were being undertaken, he was conducting further enquiries with respect to the interstate drug trafficking warrant, as well as having the substance seized from Mr McGrath tested by the Cairns Drug Squad.

Although Constable Rainbow retired from the QPS earlier this year, he gave evidence at the inquest. On 24 June 2012 he was working at the CWH with

three other officers. As he was the only male working on that shift it was his role to search males entering the watchhouse. Constable Rainbow was not informed of Mr McGrath's criminal history or of the outstanding warrants.

Constable Rainbow's evidence was that it was a common occurrence for small quantities of drugs to be found on persons entering the CWH. He did not form a suspicion that Mr McGrath was either in possession of other drugs or at risk of self harm. Constable Rainbow also conducted a heath check on Mr McGrath, who denied that he was suffering any form of depression or mental health concerns. Constable Rainbow only conducted unclothed searches when directed to do so by the watchhouse manager. Although he had no reservations about conducting an unclothed search, he considered that they can be degrading for the person being searched, and were only to be conducted in exceptional circumstances.

Constable Rainbow agreed that a pat down search did not enable any contact with a person's genital or groin area and would not reveal any contraband hidden in that area. There was a risk that something could be missed but that was also a risk with an unclothed search if something was secreted within the person.

The watchhouse manager on the relevant shift for Mr McGrath's processing (2pm – 10pm) was A/Sergeant Jennifer Noble. She was aware of Mr McGrath's drug offending history, the fact that he was wanted for interstate drug trafficking offences and flags on CrimTrac regarding suicide risk. She was also aware of the clip seal bag containing amphetamine and the sum of money that had been located on Mr McGrath. Given all of the circumstances, it was within A/Sgt Noble's discretion to direct that an unclothed search be undertaken.

During her ESC interview, A/Sgt Noble was asked about who determines the type of search that is conducted on a prisoner. It was her view that the officer dealing with the prisoner (mainly the arresting officer) determines the level of search conducted. She recalled that she was not asked by Constable Coffey to authorise an unclothed search on Mr McGrath. She indicated that if she had been asked, she would have authorised the search.

A/Sgt Noble was asked during her ESC interview why she did not authorise an unclothed search based on those factors which were within her knowledge. She said that she could have authorised a search, but that generally an officer gets an 'inkling' or a 'feeling about it' and that did not really exist with Mr McGrath. She reiterated that the other officers did not approach her about it nor did they suggest that they had a certain feeling about him either.

A/Sgt Noble also said in her interview that unclothed searches are conducted at the watchhouse in exceptional circumstances. She relies on the other officers to approach her with the circumstances relating to the prisoners as there is no way that she can sight each prisoner and make her own assessment. Generally, unclothed searches are conducted on prisoners who

have come from other correctional centres or the drug court, or prisoners who are known by police to secrete items on their person.

It was the opinion of A/Sgt Noble that if it was a requirement for an unclothed search to be conducted on every prisoner who had known drug history, watchhouse officers would be conducting unclothed searches on nearly every prisoner who would come through the watchhouse.

At the inquest A/Sgt Noble said that she had a discussion with Mr McGrath at the processing counter after Ms Van Dulken expressed some concerns about his welfare. Mr McGrath told A/Sgt Noble that he was worried about the security of his car and that people were out to 'get him'. Mr McGrath told A/Sgt Noble that he was not concerned about himself as long as he was not left alone. She stated that after she spoke with him he appeared calmer.

At the inquest A/Sgt Noble reiterated that, based on her assessment of Mr McGrath's demeanour and the relevant considerations under s.16.10.2 of the OPM, she was not able to form the view that an unclothed search was necessary. A/Sgt Noble was of the view that Mr McGrath was not an exceptional case. Of particular relevance was the fact that he had presented himself to the police station and was not noticeably affected by drugs.

Fellow watchhouse manager, Sergeant Malcolm Meadows (worked the 6am – 2pm shift on the relevant day) and Senior Sergeant Peter Deasy (OIC CWH) were both interviewed by ESC investigators. They were asked whether, in the circumstances, they would have authorised an unclothed search to be undertaken on Mr McGrath. Both confirmed they would have authorised one in the circumstances.

Sergeant Meadows and Senior Sergeant Deasy (now retired) also gave evidence at the inquest. Sergeant Meadows has worked at the CWH for over 12 years. He described the CWH as one of the busiest in the state due to the large influx of prisoners from Cape York.

Sergeant Meadows stated that even if an officer was satisfied that all the risk factors in s.16.10.2 of the OPM were present; they retained the discretion not to order an unclothed search. In his view, the factors that mitigated the risks in Mr McGrath's case were the fact that he was found to have only a small quantity of drugs in his wallet, and that he had surrendered the drugs without any attempt to conceal them on his person. He acknowledged that Mr McGrath's history of drug trafficking would be a factor that made it more likely that he would order an unclothed search.

Senior Sergeant Deasy was an officer with over 37 years experience with the QPS. He acknowledged that he had informed ESC that he would have ordered an unclothed search, but that at the time of his ESC interview he was not aware of all the circumstances. Risk factors present in this case that would have led him to order an unclothed search were the fact that Mr McGrath had drugs in his possession, his history of drug trafficking and flags

for potential self harm. He agreed that the decision was entirely within the discretion of the individual supervisor on shift.

I was assisted at the inquest by the current Officer in Charge at the CWH, Senior Sergeant Paul Gardiner. He provided a written statement and was also called to give evidence at the inquest. During September 2012, Senior Sergeant Gardiner was acting as the Officer in Charge at the CWH. He said that, as part of the debriefing which occurred after Mr McGrath's death, the Cairns District Officer requested that all staff at CWH familiarise themselves with the Watchhouse Practices Good Practice Guide. Further, he was to ensure that all staff working at the watchhouse completed the online learning product 'QC0266-02 Searches of Persons'.

In addition to completing the online learning product, Senior Sergeant Gardiner instructed his staff to familiarise themselves with the contents of s.16.10 of the OPM – Searches of Persons, as it contained current policy and legislative references.

On 28 September 2012, Senior Sergeant Gardiner was able to advise the Cairns District Officer that his staff at the watchhouse had completed the training as required. He ceased acting in the role of Officer in Charge on this date but later took up the role again on 18 February 2013.

On 24 December 2013, Senior Sergeant Gardiner provided a Risk Management Worksheet to all of his shift supervisors at the CWH. The worksheet identified unclothed searches as an issue and the current controls being used to assist in managing the risks. Those controls include the shift supervisor being required to monitor all searches conducted, ensuring that they are conducted lawfully, performed with professionalism and in adherence to the guidelines for conducting personal searches as outlined in the OPM.

## *Cairns Watchhouse staff training*

A version of the CWH Staff Orientation Package (the Package) was tendered at the inquest. The version was from January 2010. During the investigation into Mr McGrath's death, it was made clear by various witnesses that the Package was undergoing a review.

Searching prisoners is outlined on page 24 of the Package. It states, with respect to unclothed searches (commonly known as strip searches) that

> full strip searches are to be conducted at the direction of the shift supervisor, and the reasons for doing so are to be entered in a detention log on QPrime.

The Package then details how to conduct strip searches, and the practicalities of same. There is no detail as to the matters to take into consideration in deciding whether a strip search is necessary, only that they are to be done at the direction of the shift supervisor. There is a reference at the end of the section to page 127 of the Standard Operating Procedures (SOP) for the CWH. On the very first page of the Package, it is made clear that the

document is to be read in conjunction with the CWH Standing Orders and SOPs and also Chapter 16 of the OPM.

A version of the CWH Standing Orders and SOPs was also tendered at the inquest. The version of the 149 page document appears to be from 2011; however the footer of the document is dated 2007. This document covers a large variety of matters, those most relevant to this inquest being situations where illegal substances are located on prisoners, and the searching of prisoners.

With respect to the situation where drugs or illegal substances are located on a prisoner at the watchhouse, the SOPs state that the situation is to be treated the same as it would be if it occurred outside the watchhouse. The drugs are to be seized, identified and a suspect questioned and then charged if sufficient evidence exists. This procedure was followed with Mr McGrath. Once Constable Coffey located the clip seal bag in Mr McGrath's wallet, he proceeded to have the substance tested to confirm the identity of the drug. He then proceeded to formally charge Mr McGrath and offer him the opportunity to be interviewed.

The Prisoner Master List was referred to throughout the inquest by witnesses Mr Deasy and Sergeant Malcolm Meadows. That document is in fact a requirement under the SOPs. It is discussed on page 123 of the SOPs.

The searching of prisoners is outlined from page 134 of the SOPs. It confirms what is stated in the orientation package. It says:

> When it is considered justifiable, taking into consideration all relevant circumstances whereby the Cairns Watchhouse Supervisor is of the opinion a unclothed (strip) search of any person in custody is necessary the following procedures are to be followed:
>
> - Supervisors are to ensure that all prisoners are searched at the original time of being processed.
>
> - Any prisoner who has been removed from the Watchhouse for any lawful reason (e.g. medical /arrest detention etc...) upon their return to the Watchhouse, a full unclothed search is to be conducted on that person.
>
> - These standing orders are to be read in conjunction with the following sections 442, 443 and 444 of the Police Powers and Responsibility Act 2000.
>
> - Searches are to be undertaken by Officers of the same sex as the person being searched.
>
> - All property removed from a person being searched at charge counter is to be taken possession of and recorded in The QPrime Person Custody Report. Persons can also be searched by a security wand or pat searched.

- Should an unclothed search be considered necessary the Watchhouse shift supervisor shall assess the necessity the Watchhouse Supervisor may authorise a strip search of the person in custody. Under no circumstances shall an unclothed search be conducted on any person in custody without the authorisation of the Shift Supervisor.

The SOP then details the practicalities to be followed when conducting unclothed searches. The section continues:

- Particulars of unclothed searches/Pat Wand searches are to be placed in The QPrime Person Custody Report, Detention Log entry. The Detention Log entry is to be updated as per Section 54 of the PPRA 2000.

- The reason for the strip search is to be noted in the comments field in the custody index indicating time, date and registered number of officer conducting the search and the name/number of the supervisor authorising the search.

- In summary, the Cairns Watchhouse shift supervisor is the only member to authorise a strip search of any person held in custody. Prior to authorising the procedure the supervisor is to consider all circumstances of the situation, in compliance with section 649 of the PPRA and 16.10.2 Unclothed searches of persons.

- After consideration of all circumstances, should the Shift Supervisor be of the opinion the unclothed search is justifiable, lawful and necessary under the situation as presented at that particular time, then the requirements of the strip search should be undertaken.

- Unclothed searches are not to be conducted as a matter of routine, where applicable pat and or security wand searches are to be implemented.

I also had regard to a watchhouse checklist which was tendered at the inquest. The checklist was required to be filled out by an individual watchhouse officer when they had read and completed the watchhouse orientation package. The monitoring of this checklist and the timely completion of the orientation package was not done on any consistent basis.

The effect of the evidence is that the CWH is a very busy workplace with a high turnover of staff. The experience level of individual staff on shift at any given time varies. In terms of training at the CWH, it is clear that a hands on, practical approach is adopted rather than a formal written orientation. While it might be intended for all new staff to read the orientation package and SOPs, the nature of the workplace does not provide the time or circumstances for that to be done.

The evidence from the OIC at the relevant time, Peter Deasy, is that while he intended for his staff to read through the orientation package, other things

would get in the way and they would get caught up with those. This is shown by a number of officers who were interviewed as part of the ESC investigation and confirmed that they had never completed the orientation package.

New staff at the watchhouse are monitored by a supervisor, or an officer with more experience. This monitoring lasts for up to a week and then the new officers are on their own.

With respect to training on searching prisoners at the watchhouse, the evidence was that this is not taught afresh at the watchhouse and officers are to rely on their training as conducted through the Officer Skills and Tactics Training. Officers are aware that unclothed searches are to be authorised by the shift supervisor. It seems they are not trained to analyse the variety of information about any given prisoner on their own accord.

## *Medical intervention*

The adequacy of the medical response to Mr McGrath in the lead up to his death was not an issue which was canvassed in detail at the inquest. However, as it was a significant aspect of the overall picture leading up to Mr McGrath's death, I consider it appropriate for me to address it.

The evidence confirms the following timeline of events:

- At 10:55pm A/Sgt Colin Thomas (watchhouse manager for 10pm – 6am shift) conducted an inspection of all prisoners in their cells. He inspected cell M-10 and engaged in conversation with Mr McGrath. Nothing out of the ordinary was noted about Mr McGrath's behaviour or demeanour at this time.

- CCTV footage of cell M-10 confirms that by about 11:15pm there is a notable difference in Mr McGrath's behaviour and mannerisms. The evidence from the officers on duty was that it was thought Mr McGrath might have been experiencing some sort of psychotic episode.

- At about 11:30pm a prisoner in cell M8 (Eddie Pootchemunka) contacted watch house staff via cell intercom and requested that they attend to cell M-10. They were advised that Mr McGrath was acting in an aggressive and erratic manner and that Mr Gibson was experiencing some chest pain.

- As a result of the intercom call, A/Sgt Thomas attended at cell M-10 and attempted to speak to Mr McGrath. He was observed to be sweating profusely and acting in an erratic manner; in fact he appeared to be sparring. A/Sgt Thomas tried to reason with Mr McGrath by telling him to calm down and encouraging him to slow his breathing. It was confirmed during A/Sgt Thomas's ESC interview that while Mr McGrath gave no verbal response, he did appear to calm down at certain times which indicated to A/Sgt Thomas that he was listening to the directions.

- While A/Sgt Thomas was down at cell M-10, he managed to pull Mr Gibson out of the cell. Mr Gibson was placed in a holding cell. Mr McGrath's condition seemed to deteriorate as he was now lying on his back on the floor of the cell. He was still moving around the cell, deliberately punching the air.

- A/Sgt Thomas directed his fellow officers to contact the QAS for treatment to be provided to both Mr Gibson and Mr McGrath.

- QAS records confirm that the call from the watchhouse occurred at 11:36pm. Two units were dispatched (one for each prisoner), the first arriving at 11:44pm, and the second arriving at 11:51pm.

- The phone call to the QAS Medical Director Dr Stephen Rashford to request an ICP took place at midnight. Approximately four minutes into this call Mr McGrath was noted to have stopped breathing.

- CCTV footage confirms that the ACPs Papashalis and O'Leary immediately attended to Mr McGrath within the cell and commenced CPR with the assistance of the watchhouse officers. QAS records confirm that the ambulance departed the watchhouse at 12:16am and arrived at CBH at 12:23am.

It would seem that the time period from about 11:30pm through to a few minutes after midnight is the most relevant to this issue.

The applicable OPM with respect to the medical treatment of prisoners is s16.14.2. That section confirms that the duty of care for a person in custody in a watchhouse rests with the watchhouse manager. Further, the watchhouse manager is to obtain medical treatment or advice from a GMO when the watchhouse manager identifies that a prisoner is:

- In need of medical treatment
- Requesting medical treatment.

Officers are to closely monitor and continue to assess prisoners once they are in custody (s.16.13). When a situation arises where there is a high risk of excited delirium or positional asphyxia occurring, the prisoner is to be closely supervised by constant face-to-face monitoring.

It would seem that A/Sgt Thomas, as the watchhouse manager, followed the OPMs by continuing to monitor/supervise Mr McGrath and calling for medical treatment upon it being requested by Mr Gibson and apparently in need by Mr McGrath. It is difficult to see how anything further could have been done by A/Sgt Thomas.

Once the first QAS unit arrived (ACP Jeremy Lawrence on his own) he attended to Mr Gibson instead of Mr McGrath. He had a defibrillator with him. Dr Stephen Rashford confirmed in his evidence that this decision to attend to

Mr Gibson was supported by the fact that a patient with chest pains is generally given higher priority by the QAS.

Once the ACPs Papashalis and O'Leary arrived outside cell M-10, a visual assessment as opposed to a physical assessment was conducted. This was due to his erratic behaviour, and the safety of all officers involved being a matter of primary concern. The ACPs decided that the only way that treatment could progress was if Mr McGrath was sedated. The call to Dr Rashford thus took place, during which Mr McGrath was noted to have stopped breathing.

There was a slight delay in getting all necessary equipment to the cell, given that ACP Lawrence had the defibrillator with him.

In his capacity as the QAS Medical Director, Dr Rashford conducted a review of the decisions made by his QAS officers in this case. In response to the possible delay in the paramedics being able to immediately and safely enter the cell to physically assess Mr McGrath, he said that had a physical assessment been able to be conducted earlier, the seriousness of the situation would have been apparent. However, Mr McGrath's sudden deterioration was unlikely to have been averted considering the small timeframe in which he progressed into cardiac arrest after the QAS arrival.

Dr Rashford recognised the poor decision making displayed by the paramedics in not taking the necessary equipment at the outset to Mr McGrath's location in the cell. He confirmed that the relevant equipment had been taken into the watchhouse and was being used in the assessment of Mr Gibson, as his symptoms were deemed to require a more urgent response than Mr McGrath. However, Dr Rashford says that the time taken to obtain this equipment did not affect Mr McGrath's outcome as this was done at the same time as the process of the cell being unlocked and opened. He confirmed that early priority of care in cardiac arrest is effective CPR, and this was implemented per expected practice while the additional equipment was being prepared.

Dr Rashford confirmed that the paramedics involved in this case have all gone through review sessions with a senior Clinical Support Officer.

# Conclusions

I conclude that Mr McGrath died from methylamphetamine toxicity. I find that none of the watchhouse officers or inmates at CWH caused or contributed to his death.

I am satisfied that Mr McGrath was given appropriate and timely medical care by the QAS. At the time that the QAS was contacted, his death could not have reasonably been prevented.

While I acknowledge that relevant watchhouse officers were not obliged to order an unclothed search, I am satisfied that, had Mr McGrath been subjected to an unclothed search prior to his detention at the CWH, it is

possible that the further quantity of methylamphetamine would have been found and thus his death in this instance may have been prevented.

## Findings required by s. 45

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 the material contained in the exhibits, I am able to make the following findings:

**Identity of the deceased** – The deceased person was Nathan David McGrath.

**How he died** - Mr McGrath died from methylamphetamine toxicity. The death occurred after he ingested an unknown but lethal quantity of methylamphetamine while in his cell at the Cairns Watchhouse.

**Place of death** – He died at Cairns in the State of Queensland.

**Date of death** – He died on 25 June 2012.

**Cause of death** – Mr McGrath died from methylamphetamine toxicity. Coronary artery atheroma was a significant contributor to the death.

### *Comments and recommendations*

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Consistent with the principles underpinning the relevant PPRA provisions and Chapter 16 of the OPM, the evidence demonstrates a culture at the CWH which is generally and appropriately reluctant to conduct unclothed searches.

Officers who gave evidence at the inquest confirmed that they regard unclothed searches as highly intrusive, and should not be conducted as a matter of routine but only in an exceptional case. Other, less significant reasons given for not conducting an unclothed search included potential media scrutiny of unnecessary searches and the threat of litigation.

Mandatory unclothed searches were not supported by any of the witnesses or in submissions made to the inquest. It was noted that such a regime would not eliminate the risk of contraband being brought into watchhouses through other means, including concealment in body cavities.

The Queensland Police Union of Employees (QPUE) drew my attention to the procedures with respect to strip searches operating in Western Australia. In

Western Australia strip searches are required to be carried out as soon as practicable on those detainees assessed as 'high risk', including those who:

- have previously been or are currently charged with drug offences
- are known to be suicidal
- have previously been charged or convicted of, or are currently charged with concealed items or weapons.

The QPUE submitted that it was appropriate for a fresh inquiry to be conducted into the issue of strip searching in Queensland given that 14 years have passed since the CJC Inquiry. The QPUE acknowledged that it was necessary to balance the rights and interests of all persons in watchhouses.

The inquest heard evidence that some contraband apart from drugs has found its way into the CWH, including cigarette lighters, batteries, razor blades and a rock. However, there was no evidence that such occurrences were regular or that the current policy regarding unclothed searches contributed to these items entering the watchhouse.

The QPS submitted that the current policy with respect to unclothed searches is adequate. Section 16.10.2 provides officers with a lengthy and detailed set of considerations upon which to base the exercise of their discretion. These considerations are consistent with the principles underlying the PPRA and those recommended by the CJC in its 2000 Report.

The current policy surrounding unclothed searches is open to individual interpretation, and is applied in a subjective manner. This is obvious in this case given the differences of opinion among the senior officers at the CWH.

OPM 16.10.2 contains a detailed list of risk factors officers are to consider in assessing whether an unclothed search is appropriate. Even if all risk factors are present, officers are to be satisfied that it is not practicable to prevent the identified risks being realised by some other means, and have the discretion to decide not to conduct an unclothed search.

I do not consider that the evidence heard at this inquest provides a sufficient basis for recommending a change to the current policy on unclothed searches. Whether a more fundamental review of the policy is warranted is a matter for consideration by the QPS.

I have considered the training of staff at the CWH and I am satisfied that a practical approach is the most effective method of training. In conducting this training, officers at the CWH should place greater emphasis on the matters contained in s.16.10.2 of the OPM.

I have considered whether any police guidelines should be changed so as to prevent a similar death occurring in the future. I am satisfied that the CWH Staff Orientation Package and Standing Orders and SOPs should be amended so as to place greater emphasis on s.16.10.2 of the OPM.

Further, having regard to Senior Sergeant Gardiner's evidence and the changes he has made to policy at the CWH, I am satisfied that these changes will assist in preventing a similar death occurring at the CWH.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
17 April 2014