QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Charles Kingston HURST**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maryborough
FILE NO(s):	COR 2012/4053
DELIVERED ON:	16 September 2014
DELIVERED AT:	Maryborough
HEARING DATE(s):	12 June 2014 & 15-16 September 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; hanging

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Partner of Mr Hurst:	Mr Simon Burgess (Instructed by ATSILS)
Queensland Corrective Services (Department of Justice and Attorney-General) :	Ms Jennifer Rosengren
West Moreton Hospital & Health Service	Ms Holly Ahern

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Introduction

Charles Hurst was 38 years of age when he was found hanging in his cell at Maryborough Correctional Centre in the early hours of 7 November 2012. In the preceding months he had, at various times, been accommodated in the MCC safety unit due to self-reported suicidal ideation. Two days prior to his death Mr Hurst's risk classification was lowered and, having already begun a process of reintegration, he was returned to a regular cell. The drawstring on a prison laundry bag, thinner than it should have been, enabled Mr Hurst to fashion a noose through the otherwise inaccessible holes in an air vent.

These findings:-

- confirm the identity of the deceased person, the time, place and medical cause of his death;

- examine the compliance by corrections staff with procedures and policies in place at MCC governing the assessment of risk of self-harm and/or suicide; and

- consider whether adequate steps have been taken to restrict access to the material used by the deceased to hang himself.

The investigation

An investigation into the circumstances leading to the death of Mr Hurst was conducted by Detective Sergeant Richard Libke from the Queensland Police Service Corrective Services Investigation Unit (CSIU).

Local CIB officers took initial carriage of the investigation arriving at approximately 4:00am on 7 November 2012. Mr Hurst's cell had been sealed off by MCC staff and, at the direction of CIB investigators, a scenes of crime officer examined the scene and took a series of photographs which were tendered at the inquest.

Detective Sergeant Libke and a colleague travelled to Maryborough, were briefed by investigators, and inspected the scene. Together they conducted interviews with 48 other prisoners at MCC and took detailed statements from the two prisoners who had acted in a peer support capacity for Mr Hurst. The CSIU investigators took statements from all relevant prison staff, they secured prison security and medical records pertaining to Mr Hurst and examined CCTV footage.

Statements were taken from Mr Hurst's current and former partners when it emerged that they had expressed concern about his mental state to MCC staff prior to his death. The investigators seized the medical file relating to Mr Hurst and obtained a statement from his treating psychiatrist.

A separate investigation was ordered by the Chief Inspector, Queensland Corrective Services (QCS). That resulted in a detailed report which was provided to investigating police and my Office. The report made a number of findings and recommendations which are discussed later in these findings.

I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed. I thank Detective Sergeant Libke for his efforts.

The Inquest

A pre-inquest conference was conducted on 12 June 2014. Mr Johns was appointed as counsel assisting and leave to appear was granted to Mr Hurst's partner, Queensland Corrective Services within the Department of Justice and Attorney-General and the West Moreton Hospital and Health Service, which now oversees the provision of mental health care at MCC.

The inquest was held in Maryborough on 15 September 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Two witnesses gave oral evidence.

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

The evidence

Mr Hurst's custody

Charles Kingston Hurst ('Charlie' to his friends and family) was born on 14 September 1974. He spent three and a half years in prison from 1999 onwards and a further three months in mid 2011.

On 16 November 2011 Mr Hurst was sentenced to 18 months imprisonment with a parole eligibility date of 29 November 2011. He was released on parole on that date. However, when he failed to comply with the terms of that parole a return to prison warrant was issued by the Parole Board. The warrant was issued on 21 February 2012 and executed on 1 August 2012, at which time Mr Hurst was returned to MCC.

After being sentenced for further offences on 18 September 2012, Mr Hurst had a new parole eligibility date of 18 December 2012 and a full-time discharge date of 6 February 2014.

Mr Hurst had no history of misbehaviour or any other breach of conduct while in QCS custody.

Psychiatric History and treatment

Mr Hurst had been diagnosed with schizophrenia, depression and anxiety. On his return to MCC in August 2012 he initially suffered severe withdrawal symptoms from alcohol and drugs.

After referral to the prison Mental Health Service, Mr Hurst was seen regularly by psychiatrist, Dr Vikram Goel, from 17 September 2012. When seen by Dr Goel on 17 September, Mr Hurst was future oriented and outlined appropriate plans. Dr Goel determined that there was no evidence of primary mental illness but agreed to continue the existing prescription of Mirtazapine, and on 15 October 2012 prescribed Chlorpromazine. This prescription was made after considering records from 2010 and 2011 when Mr Hurst was engaged with Maryborough and Townsville Mental Health Services. At that time he was trialled on various antipsychotic medications, tolerating Chlorpromazine the best.

The recurring theme of Mr Hurst's condition was an apparently delusional belief that other prisoners associated with a criminal motorcycle gang would try to harm him and his family in relation to unpaid debts. These debts related to events many years earlier and repeated investigations by prison staff failed to establish any evidence that other prisoners were seeking to harm Mr Hurst. Nonetheless, the concern was very real in his mind and undoubtedly led to significant stress and anxiety.

First notice of concern

QCS At-Risk Management Procedures establish a system for the initial assessment and ongoing monitoring of the risk of suicide and self-harm among the prison population. The policy requires that a new prisoner undertake an Initial Risk/Needs Assessment (IRNA). This was appropriately conducted by a QCS psychologist when Mr Hurst was returned to MCC on 1 August 2012.

The IRNA for Mr Hurst noted a review of the QCS information management system. The review revealed Mr Hurst had previously disclosed to prison staff a history of suicide attempts and this was again disclosed by Mr Hurst on 1 August 2012. It was confirmed that there was no history of suicide attempts or self-harm by Mr Hurst during previous periods of incarceration. Mr Hurst's presentation at this time justified the opinion that he was not at elevated risk of suicide or self-harm and as a result did not fall within the auspices of the At-Risk Management Procedures.

On 10 August 2012, Mr Hurst approached a Corrective Services Officer stating that he was delusional, hearing voices, sweating and shaking. He was having suicidal thoughts. This resulted in a Notice of Concern being generated; a step which automatically sets in train the QCS At-Risk procedure. The policy calls for an immediate assessment and this was conducted by the Senior Psychologist at MCC, Steven Mitchell, who gave evidence at the inquest.

Following his assessment on 10 August 2012 Mr Mitchell assessed Mr Hurst as being at 'medium' risk of suicide or self-harm. Consistent with this assessment, he recommended that Mr Hurst be transferred to the Safety Unit at MCC and placed on an hourly observation regime. This was immediately implemented.

The At-Risk regime then required Mr Hurst's case to be considered at least weekly by a Risk Assessment Team (RAT). This process involved Mr Hurst's risk classification being individually assessed by a custodial supervisor and a psychologist.[1] The assessments were considered and discussed by the RAT and a final risk level agreed upon. Mr Mitchell told the inquest that where there was a divergence of views with respect to the risk level the more conservative was adopted.

The RAT meeting on 16 August resulted in a 'medium' level of risk and hourly observations were maintained. On 24 August Mr Hurst was re-classified as 'low' risk and he began to spend days in the general population in unit S3. His observation regime was reduced to every 120 minutes.

By this time Mr Hurst had also applied for status as a protected prisoner (which is unrelated to the At-Risk procedure). This application was later approved. The inquest heard that unit S3 was chosen for Mr Hurst as it was known to house the least violent prisoners and was suitable for protected prisoners. It was most suitable given Mr Hurst's wariness of others. At the RAT meeting on 31 August 2012 Mr Hurst was assessed as no longer being at risk of self-harm or suicide and placed full time in unit S3.

Second notice of concern

On 11 October 2012 Mr Hurst approached the officers' station in unit S3 and stated that he was feeling suicidal. He was assessed by psychologist Paula Piscitelli, who considered that he was at medium risk of suicide. As had occurred previously, he was transferred to the Safety Unit and placed on hourly observations. The At Risk procedure again saw his case considered weekly by the RAT.

The first RAT meeting after the assessment was on 15 October 2012. This, and the 29 October 2012 RAT meeting, coincided with appointments for Mr Hurst to see his treating psychiatrist, Dr Goel.

The RAT meeting affirmed the assessment of medium risk and the hourly observation regime was maintained.

At the inquest Mr Mitchell explained that in almost all cases the goal of the RAT was to safely re-integrate prisoners back into the mainstream population of the prison. The Safety Unit, while designed to prevent suicide or self harm, was a particularly invasive and uncomfortable environment for prisoners. If housed there long term it would likely be detrimental to their mental health. In

[1] The initial RAT meetings also considered assessments by other staff members including a counselor. The policy was later changed to require just the two assessments noted above.

the specific case of Mr Hurst there was also an understandable view that by keeping Mr Hurst isolated from the main prison population it would affirm his belief that the main prison population was something to be afraid of and avoided. Mr Mitchell explained that Mr Hurst, for the most part, seemed to have good insight into this issue and the reality that his fears were delusional. Mr Hurst was not always preoccupied with these thoughts. Rather, they were of a transient nature.

Mr Mitchell considered that staff at the MCC had established a 'therapeutic alliance' with Mr Hurst such that if he felt concerned for his well-being he would self present to staff. He had demonstrated a willingness to do so on a number of previous occasions. In his experience, past behaviour was the best predictor of future conduct.

On 16 October 2012 Mr Hurst received news that his uncle had died. Arrangements were made for another prisoner in unit S3 who had provided peer-support on previous occasions to visit Mr Hurst. The two assessments conducted for the 22 October 2012 meeting were split between low and medium classifications of risk. As such the medium classification, and hourly observations, remained in place. This situation was repeated at the RAT meeting on 29 October 2012.

Dr Goel provided a statement to the inquest noting that on 15 and 29 October 2012 Mr Hurst stated that his symptoms had almost resolved and he denied thoughts of self harm. He stated that he would approach QCS staff if any suicidal thoughts re-emerged. This was the pattern of behaviour that he had established in the past. He was accepting of treatment and Dr Goel increased the dosage of Mirtazapine.

On 4 November 2012 Mr Hurst was visited by his former partner, Karen Daveson. After the visit Ms Daveson approached an officer and was referred to Correctional Supervisor Jespersen to relate concerns she had about Mr Hurst's mental state. Ms Daveson had not seen Mr Hurst for a lengthy period and relayed concerns Mr Hurst had that other prisoners were going to kill him. She was concerned that some of the comments he had made were consistent with someone considering suicide. Mr Hurst was interviewed by Corrective Supervisors Jespersen and Mullen. He was unable to substantiate the claims that other prisoners wanted to kill him and he denied any suicidal thoughts.

The following day Mr Hurst's current partner phoned the prison following a conversation with Ms Daveson, and expressed her concern for Mr Hurst's welfare. CSS Jespersen and a psychologist, Narelle O'Brien, were both aware of these concerns when they interviewed Mr Hurst on 5 November 2012 as part of their assessments for that days RAT meeting. Mr Hurst again denied any suicidal ideation. He did not present as anxious or having depressive symptoms, and was not reporting hopelessness. He discussed his future plans to start a lawn mowing business on release and plans for his re-integration into unit S3 were discussed.

RAT meeting on 5 November 2012

The outcome of the 1:30pm RAT meeting on 5 November 2012 was that Mr Hurst's risk classification was changed to 'low'. This had the practical effect of his observation regime being reduced to every 120 minutes and he was returned to unit S3 on the morning of 6 November 2012.

Later on 6 November 2012 Mr Hurst's sister Debbie phoned the prison and spoke to counsellor Clair Thompson. She told Ms Thompson that Mr Hurst was making unusual phone calls claiming that people in the community were seeking to kill his partner. He also expressed concerns about his lack of money. There is no indication that he expressed suicidal thoughts and it appears that Mr Hurst's concerns for the welfare of his partner again related to his ongoing concerns relating to unpaid debts. Ms Thompson noted the conversation and indicated that Mr Hurst would be seen on the morning of 7 November 2012 for follow up.

Mr Mitchell told the inquest that Ms Thompson was part of his team and, in the normal course this was the type of issue she might raise at their morning meeting. Although she was one of only two counsellors serving more than 400 prisoners (today there is just one for an even greater number), either she or one of the psychologists would have been available to meet with Mr Hurst. Mr Mitchell told the inquest that he received numerous calls of concern for the welfare of family members in custody each day.

The hanging and discovery of Mr Hurst

Mr Hurst was locked in his cell shortly prior to 6:00pm on 6 November 2012. CCO Kelli Maragna was assigned to check on Mr Hurst at 12:55am at which time she saw him roll over on his bed. At around 2:25am (well within the 120 minute observation requirement) CCO John Davis entered Mr Hurst's cell and found him hanging. It later became apparent that Mr Hurst had used the drawstring from a laundry bag to create a loop attached to an air vent above his toilet sink. That allowed him to attach a ligature formed from bed sheets.

A code blue medical emergency was immediately called and nursing staff attended promptly. Sadly, it was evident at a very early stage that there were no signs of life and no prospect of resuscitation. Queensland Ambulance Service officers declared Mr Hurst deceased shortly after their arrival at 2:50am.

Investigation findings

CCTV footage of Unit S3 at MCC established that no person entered Mr Hurst's cell after lockdown on 6 November 2012 until he was discovered to be hanging the following morning. That footage also showed that there were no suspicious movements of staff or prisoners in other nearby communal areas.

The cell in which Mr Hurst was accommodated exhibited no signs of disruption or violence beyond the materials used to fashion the ligature.

No other prison officer or inmate reported concern or suspicion in relation to the possibility of foul play or the involvement of a second party in the death of Mr Hurst.

Autopsy results

An external examination was carried out on 12 November 2012 by forensic pathologist Professor Peter Ellis.

A post mortem CT scan was conducted. Samples of blood and vitreous humour were taken and subjected to toxicological analysis. Fingernail clippings were collected in case biological analysis became necessary.
In his autopsy report Professor Ellis stated:

> *A mark consistent with having been caused by a circumferential neck ligature was observed and was consistent with the pieces of white bed sheet which were received within a sealed evidence bag. Careful external examination showed no evidence of other injuries or anything to suggest restraint or the involvement of another person.*

After considering all of the available information Professor Ellis issued a certificate listing the cause of death as:

1(a). Hanging

Conclusions

I am satisfied that Charles Hurst hanged himself in the early hours of 7 November 2012 and that no other person was involved.

I consider that the quality of psychiatric health care provided by the Prison Mental Health Service was adequate and commensurate with that which Mr Hurst might expect to receive in the community.

I am satisfied that the QCS 'At Risk' procedure was applied properly and, for the most part, to a very high standard by Mr Mitchell and his team. I have given consideration to whether more weight should have been given to the concerns raised by family members on 5 and 6 November 2012. In doing so I am mindful that the concerns were centred on Mr Hurst's concerns that he or his family might be attacked in relation to outstanding debts.

This information would not have been new to the staff at the prison who had been dealing with this aspect of Mr Hurst's condition over preceding months. In any event, the concerns raised on 4 and 5 November 2012 gave rise to interviews with Mr Hurst by those who were required to assess his risk at the RAT meeting on 5 November 2012.

The phone call on 6 November from Mr Hurst's sister made no reference to possible suicidal ideation. It is important that in assessing what might constitute a reasonable response to that call it is considered prospectively. Obviously the call takes on a poignancy given the events later that evening but at the time, in the absence of a particular concern over self harm or

suicide, the actions of Ms Thompson were entirely appropriate. I am satisfied that the systems at MCC were such that a further interview would have been conducted with Mr Hurst on 7 November 2012 to discuss these concerns.

I accept that on the occasions that Mr Hurst had expressed suicidal thoughts following his imprisonment in August 2012 he had not taken any steps in preparation to harm himself, nor was there any clear evidence that he informed anyone of a specific plan to commit suicide.

I adopt the finding of the QCS Office of Chief Inspector report which found:

> *"…the laundry bag string and toggle that prisoner HURST used to attach his noose to the vent in his cell was thinner and longer than the original laundry bag design that was approved for use by the Prisoner Employment Governance Committee. This slippage in laundry bag design/production standards directly contributed to the incident because it is unlikely that prisoner HURST would have been able to thread the original string and toggle through the holes in the vent a significant point when cells are designed to limit hanging points."*

This was clearly a failure which ultimately contributed to the ease with which Mr Hurst was able to take his own life (and, therefore, the likelihood that he would). There is no evidence that there was any malicious intent associated with the mistake in design.

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

Identity of the deceased – The deceased person was Charles Kingston Hurst.

How he died - Mr Hurst used the drawstring from a prison laundry bag and his bed sheets to form a ligature in his cell, and then hanged himself while in custody at Maryborough Correctional Centre.

Place of death – He died at Aldershot in Queensland.

Date of death – He died on 7 November 2012.

Cause of death – Mr Hurst died from hanging.

Comments and recommendations

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

I have considered the findings and recommendations made in the detailed report prepared on behalf of the QCS Office of Chief Inspector. I consider the three recommendations set out below to be appropriate and adequate to the circumstances of Mr Hurst's death:

1. *QCS reiterate support for the 2013 Health Prison Inspection recommendation that staff should not undervalue current symptomology on the basis of past experience of the prisoner by re-communicating this information statewide to all centre management and psychological services staff.*

2. *QCS implement a resilience training or education program for a specified cohort of prisoners who are identified as a high elevated risk of suicide on a statewide basis.*

3. *That centres be required to obtain the approval of the Safety and Security Committee in respect of proposed non-urgent changes to practice that are inconsistent with safety or security related directions issued by the Statewide Operations directorate such as, for example, changes to designated adjustment mechanisms for laundry bags. In addition, urgent changes that are approved by statewide operations outside the Safety and Security Committee process should be submitted in the next committee meeting for endorsement.*

In preparation for this inquest I issued a requirement that QCS summarise its progress in the implementation of those recommendations. The evidence tendered as a result of this establishes (by reference to the three recommendations above) that:

1. On 6 March 2014 an instruction was issued by the Deputy Commissioner, QCS to general managers of all correctional facilities noting changes to the QCS At-Risk Management procedure insofar as it related to indicators of at risk behaviour. The changes adopted the recommendation by noting the importance of attaching appropriate weight to current symptomology of presenting inmates.

2. This recommendation is to be implemented by 30 May 2015. A suitable education program has been identified and the inclusion of the principles set out in the recommendation is being assessed.

3. The laundry bags in use at MCC at the time of Mr Hurst's death were withdrawn from use statewide when their link to his suicide was drawn to the attention of the QCS. The inquest heard that all laundry bags in

Queensland prisons now utilise a zip mechanism rather than drawstrings.

As a result I am satisfied that the recommendations have been or will be adequately implemented.

I close the inquest.

Terry Ryan
State Coroner
Maryborough
16 September 2014