CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Luke Cunningham**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/4151
DELIVERED ON:	26 July 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	28 June 2021, 19 July 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, suicide, death in custody, young remand prisoner, shared cell, hanging points.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lio-Willie
Queensland Corrective Services:	Ms Jesika Franco, Crown Law, instructed by Ms Megan Lincez (QCS)
GEO Group Australia:	Mr Benjamin Dighton, instructed by Mr Doug Johnson (Ashurst)

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Introduction

1. Luke Cunningham was aged just 21 years when he died at the Arthur Gorrie Correctional Centre (AGCC) on 15 September 2018. Mr Cunningham was on remand at AGCC on charges of murder and other indictable offences when he was found hanged in his cell. He died two days before his 22nd birthday.

The investigation

2. An investigation into the circumstances surrounding Mr Cunningham's death was conducted by Detective Senior Constable Amanda Watt of the Corrective Services Investigation Unit (CSIU). The investigation report, finalised in June 2020, found there were no suspicious circumstances surrounding the death.

3. CSIU officers went to AGCC together with forensic officers. A crime scene had been established by QCS officers in the cell. Other prisoners were already locked down in their cells. A search of the cell revealed no suspicious circumstances. A fingerprint examination confirmed Mr Cunningham's identity.

4. CSIU detectives later seized prison and medical records relating to Mr Cunningham. They conducted interviews with other prisoners in his unit at AGCC. Statements were also obtained from Corrective Services staff at AGCC.

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

6. Inspectors appointed by the QCS Chief Inspector also investigated Mr Cunningham's death and prepared a report which was tendered at the inquest. The Office of the Chief Inspector (OCI) report included four recommendations that are considered later in these findings.

The inquest

7. At the time of his death, Mr Cunningham was a prisoner in custody, as defined in Schedule 4 of the *Corrective Services Act 2003* (Qld). As Mr Cunningham's death was a 'death in custody' an inquest was mandatory.

8. The inquest was held at Brisbane on 19 July 2021. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence.

9. Leave to appear was granted to Queensland Corrective Services (QCS) and the GEO Group Australia Pty Ltd, the operators of AGCC at the time of the death. The Queensland Government (QCS) commenced operations and the management of AGCC from 1 July 2020. A staff member from AGCC who carried out welfare checks and was involved in resuscitation efforts gave evidence, together with DSC Watt and Mr Cunningham's cellmate, Mr HD.

10. The issues considered in the inquest were the findings required by s45(2) of the *Coroners Act 2003* (Qld), and whether there are ways to prevent a death occurring in similar circumstances in the future. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal history[1]

11. Mr Cunningham was the only son of three children. His parents divorced when he was aged 8 but maintained an amicable relationship throughout his childhood, celebrating birthdays and holidays together.

12. Mr Cunningham's mother clearly loved her son. She said that he was a very clever and talented child who was involved in activities such as rugby league, music and art.

13. Mr Cunningham first ran away from home at the age of 12 and soon came to the attention of police. When he turned 14, he started chroming and using drugs after moving into the home of a woman at Deception Bay. Mr Cunningham's mother suspected this person was grooming him. His antisocial behaviour then escalated, resulting in him appearing before the Childrens Court of Queensland for property, drug and violence offences. At age 17, Mr Cunningham disclosed to his mother that he suffered from extreme anxiety.

14. Mr Cunningham became increasingly estranged from his family as he matured, and his offending behaviour escalated. After he was charged with murder, contact with his family largely ceased. Mr Cunningham had a very significant addiction to drugs including methylamphetamine and heroin.

15. Mr Cunningham had met his partner at the beginning of 2018 and lived with her from February to April 2018. They maintained frequent contact after he was imprisoned.

Criminal history

16. Mr Cunningham served his first period of detention at 17 years old.[2] Upon his release, Mr Cunningham's adult criminal history was consistent and included assaults, property offences and breaches of bail.[3]

17. Mr Cunningham's final conviction was on 31 January 2017 in the Caboolture Magistrates Court, for three charges of burglary, one of attempted enter dwelling with intent, and stealing. He was sentenced to a head sentence of 12 months imprisonment with parole eligibility after serving one month in custody. He was on parole at the time of the commission of those offences.

18. Mr Cunningham was first received into Queensland Corrective Service (QCS) as an adult on 21 January 2015. He was released on parole on 19 May 2015, but was received back into custody on 29 May 2015 when his parole was revoked.

19. Mr Cunningham was released on parole on 21 June 2015, but his parole was revoked again, and he returned to custody on 22 October 2015.

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[1] Ex B20 – Statement of mother.
[2] *R v Cunningham* [2014] QCA 88.
[3] Ex C1 – Queensland Criminal History.

20. Parole was granted on 24 June 2016 and then revoked again with Mr Cunningham returned to custody on 23 August 2016. He then remained in custody until his full-time discharge date on 30 January 2018.

21. On 20 April 2018, Mr Cunningham was charged with the murder of Jacob Bell and other offences committed earlier that day and was remanded in custody. He was transferred to AGCC on 24 April 2018, where he remained until his death.

22. An Immediate Risk Needs Assessment was conducted at AGCC on 24 April 2018 by Provisional Psychologist, Ms Alexandra Catt. Mr Cunningham denied having personal safety concerns or association issues within the centre. He denied a history of suicidal or self-harm ideation, and there was no available information to the contrary. He presented as future oriented and expressed a desire to return to a normal life after release.[4]

23. Mr Cunningham cited his partner as his main source of external support. Minimal current risk of self-harm or suicide was identified. He denied having previously seen a psychologist or counsellor or having any psychiatric diagnoses. Mr Cunningham disclosed a history of regular heroin and methylamphetamine use. His expectation at that time was that he would be incarcerated for two months; however, he reported that he would cope should he be incarcerated for any significant period. He presented as calm, stable and accepting of the current situation.

24. Mr Cunningham's Offender Case File recorded that a Transition from the Community Checklist was completed during the IRNA interview, and there were "*no significant transitional issues identified or follow up required*".[5]

25. On 2 May 2018, Mr Cunningham was seen by a social worker from The Park Centre for Mental Health following a referral from Ms Catt due to his history of ADHD as a child and following the charge of murder, noting that his mood was "flat/withdrawn". Mr Cunningham declined to participate in the interview with the PMHS social worker. He said, "*I don't mean to be rude miss but I'm all good so can I go now please".* He was then closed to the PMHS as he declined service.

26. Mr Cunningham had no other known medical or psychological conditions, apart from hepatitis C. At no time during his custodial history did he disclose or seek any assistance for mental health concerns.

Events leading up to the death

27. Mr Cunningham was housed in Unit C3 from 23 August 2018. He was accommodated in Cell 8 with one cellmate, Mr HD. They had been cellmates for about four weeks. Neither had raised any concerns about the shared cell arrangement and it was recorded that both prisoners agreed to be accommodated together.[6]

28. Although AGCC had a stated capacity of 1000, it held around 1179 prisoners on 15 September 2018. Forty prisoners were housed in Unit C3.

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[4] Ex H3.
[5] Ex D2, page 4.
[6] Ex D2, page 8.

29. On 15 September 2018, between 8:00am and 11.30am, Mr Cunningham made 19 phone calls, 12 of those calls were either voicemails or brief calls to indicate he had no phone credit, all of which were less than 45 seconds in duration.[7]

30. Seven phone calls were made to his partner or friends. Each call was in the presence of or involved his partner, who was in Sydney at the time for a music festival. She was in the company of her friend and several of Mr Cunningham's male friends.

31. In several phone calls, Mr Cunningham was audibly frustrated and angry with his partner, accusing her of being unfaithful, not making him a priority, not caring about him, and not wanting to talk to him when she was around other people. His partner told him she would not be able to visit him on his birthday as she would be working.

32. In the final two phone calls, Mr Cunningham spoke with his partner's friend. He relayed his grievances with his partner to that friend. During the penultimate call he became angry with his partner and told her she '*treats him like a grub'* and the phone call was cut off.

33. In the final call, Mr Cunningham told his partner "*this is my last phone call"* and continued to say how her behaviour hurt him. By the end of the phone call he apologised to his partner for ruining her weekend away by the things he said. They appeared to end the conversation on a positive note, saying "*I love you"* to each other.

34. Mr Cunningham seemed content after the final phone call to his partner. However, he was observed by other prisoners as apparently upset when he hung up the phone and he 'walked laps' of the yard.

35. At 4.30pm all prisoners were locked down in their cells for the night. Mr HD took medication daily for anxiety. He told the inquest that this made him drowsy and caused him to fall asleep early. Mr HD went to bed at about 6:30pm on the bottom bunk. Mr Cunningham lay on the top bunk and was watching television.

36. Custodial Correctional Officer (CCO) Mildren conducted a welfare check at 8.34pm and Mr Cunningham was seen to be alive at that time. She recorded that he and Mr HD were both lying in their beds. At the inquest CCO Milden said that she conducted welfare checks by observing the rise and fall of a prisoner's chest. She was only allocated to Unit C3 for the purpose of headcounts and did not otherwise know Mr Cunningham.

37. At about 11.25pm, Mr HD woke up to go to the toilet. When he returned to his bunk, he saw Mr Cunningham standing in the corner of the room near the cell door and he asked if he was okay, and then got back into bed.

38. Mr HD told the inquest that after Mr Cunningham did not respond, he had a bad feeling and he got out of bed to check on him. He realised Mr Cunningham's feet were not touching the ground, only his toes. He touched him and found him cold to touch. He also felt liquid on the floor of the cell where he was standing. Mr HD used the intercom in his cell and immediately notified CCOs that Mr Cunningham had hanged himself.

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[7] Ex F25, F31 – F41 – Arunta calls.

39. CCO Parslow was working at AGCC as the Master Control Officer that night. At 11.27pm he answered the intercom call from Mr HD, and he called an "Alert – Code Blue – C3 Cell 8 – Prisoner hanging". CCO Parslow directed Mr HD to try and lift Mr Cunningham up and support his body until CCOs would reach the cell. The Queensland Ambulance Service were also called to attend.

40. At 11.34pm, six CCOs and two nurses entered the cell and used a "cut down" knife to cut the ligature and lay Mr Cunningham down in the cell. They relocated him to the hallway, where there was more space, and commenced CPR.

41. CCO Mildren said that when she arrived at the cell, she saw through the window Mr Cunningham was hanging up against the wall to the left of the door with Mr HD holding him up. It was difficult to see from outside the cell. After Mr Cunningham was cut down by CCOs Mr HD sat on the bed in the cell. She said that he appeared 'flat'. Mr HD was then moved to the medical unit where he was placed on an observations regime.

42. Contemporaneous notes provided by CCO Mildren indicated that Mr Cunningham was clammy and grey in appearance. Paramedics had informed her that he had been deceased for some time.[8]

QAS attendance[9]

43. Advanced Care Paramedics (ACP) arrived at Mr Cunningham's cell at 11.47pm and observed the CCOs performing effective CPR. Mr Cunningham appeared pale and had significant ligature marks with bruising to his anterior neck. The ACPs took over management of Mr Cunningham's airway and instructed CCOs to continue chest compressions.

44. The defibrillator was applied to Mr Cunningham and it indicated the cardiac rhythm was asystole. A Critical Care Paramedic (CCP) arrived at 11.50pm and paramedics continued to treat Mr Cunningham. His airway was unable to be managed effectively due to the ongoing presentation of blood, despite suctioning.

45. At 11.58pm a final cardiac rhythm analysis was conducted, which displayed an asystole rhythm. Mr Cunningham was declared life extinct at 11.59pm.

Autopsy results

46. On 17 September 2018, Senior Forensic Pathologist, Dr Nathan Milne, conducted an autopsy consisting of an external and full internal examination of the body together with an whole body CT scan.

47. The external examination showed an injury on the neck which was partially a band-like abrasion. This was consistent with a ligature such as the jumper that was found tied around Mr Cunningham's neck. There were no petechial haemorrhages on the linings of the eyes, lips or face, which is consistent with full suspension hanging. There were no other significant injuries.

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[8] Ex B5.1.
[9] Ex B13 – Statement of Meghan Finch, ACP; B14 – Statement of Danica Kimmins, ACP.

48. The internal examination showed no injuries to the neck, which is not uncommon in deaths from hanging. There was no significant pre-existing natural disease. There were fractures of the sternum and ribs, consistent with resuscitation efforts.

49. The CT scans showed no injuries to the internal structures of the neck, which is also not uncommon in deaths from hanging. The toxicology showed no alcohol or drugs in his system.

50. Dr Milne concluded that the cause of death was hanging. The findings were consistent with hanging by the jumper, with the body fully suspended. Dr Milne remarked there were no findings to suggest the involvement of another person in Mr Cunningham's death, but such suggestion could not be excluded on post-mortem examination.

Investigation findings

51. Cell 8 was on the northern side of unit C3, along the ground floor hallway. The cell had a single door, a bunkbed, a wall mounted cabinet, a wall mounted desk, a toilet and shower. Above the door to the cell and the wall mounted cabinet were two narrow louvre windows. As depicted below, the windows had two horizontal metal security bars with vertical cross bracing.[10]

52. Mr Cunningham had used his prison issued jumper as a makeshift ligature. The jumper was tied around the cross bracing of the security bars/louvres above the cabinet.

[10] Ex D4, Figure 3.

53. All prisoners in Unit C3 were interviewed by investigators. All of them told investigators that Mr Cunningham was well liked in the unit. He did not have any problems with anyone, was "happy go lucky" and his death came as a shock. Many prisoners recalled Mr Cunningham talking about his future once he was released from custody.

54. Some prisoners[11] indicated that Mr Cunningham was obviously worried about being charged with murder, and that it would "do anyone's head in". They described him as being generally stressed about facing life imprisonment, but he never discussed the charge, or expressed anything that would indicate he was at risk of self-harming.

55. Other prisoners recalled Mr Cunningham often had heated phone calls with his partner, and on the day of his death he appeared angry after speaking with her and he "cut laps" of the yard. One prisoner joined him on his laps and Mr Cunningham disclosed that he was upset it was his birthday in a couple of days and his partner was in Sydney at a music festival and not coming to visit him.

56. The other prisoners recalled Mr Cunningham was happy throughout the day and ultimately happy before they went into lockdown for the night.

57. Mr Cunningham's partner said that there was no indication during her telephone conversations with him on the day of his death that he intended to self-harm. She said that he was generally a happy and positive person, although he sometimes felt sad and alone in prison and facing a lengthy sentence. Mr Cunningham had not expressed any concerns about his safety in prison and had no enemies.

58. Mr Cunningham's cellmate, Mr HD, told the inquest that Mr Cunningham was a "friend of a friend". He had no concerns about sharing a cell with him. He described him as a "bubbly, chatty and happy" person who was well liked in the unit. He said that while Mr Cunningham was facing a lengthy term of imprisonment he spent "time on his brief", and was preparing to fight the charges against him.

59. Mr HD had asked Mr Cunningham if he was okay and if he had an argument with his partner, but he denied he was upset. He said that while Mr Cunningham was a "bit sombre", there was nothing out of the ordinary when they were locked down for the evening. He said that he slept on the bottom bunk and put a towel up as Mr Cunningham was sitting up watching television, and Mr HD went to sleep at approximately 6:00 to 6:30pm.

60. Mr HD was interviewed by investigators. He was candid during his interview and was audibly distressed when he recounted the discovery of Mr Cunningham. Mr HD tearfully described struggling to support Mr Cunningham's body weight because he was "so cold and so heavy".

61. There were no injuries observed on Mr HD to suggest he had any involvement with Mr Cunningham's hanging. Similarly, there was no evidence of defensive wounds, facial petechia, foreign matter under Mr Cunningham's fingernails or any other evidence of a struggle.

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[11] Ex F8, F16, F17.

62. Investigators concluded that Mr Cunningham took his own life and there was no evidence to implicate other prisoners as having any knowledge or involvement in his death.

63. The investigation also concluded that Mr Cunningham was treated well during his time at AGCC, and received adequate medical care and treatment once the alarm was raised.

64. The investigating officer made no recommendations as to how this death or deaths of this type could be prevented.

Office of the Chief Inspector Investigation

65. The OCI report was dated July 2020. The OCI investigation found no evidence that QCS or the GEO Group knew, or should have known, that Mr Cunningham planned to commit, or was at increased risk of committing suicide.

66. Although the investigation found several minor departures from applicable procedure, investigators were satisfied that staff managed Mr Cunningham appropriately and responded to the discovery of him hanging in a prompt, efficient and professional manner. It was noted that by the time the Code Blue alert was called it was too late to prevent Mr Cunningham's death. Notwithstanding, the OCI Report concluded that the officers and nurses who responded to the incident performed their duty admirably and made every effort to prevent the death.

67. The investigation identified that the CCOs tried to use a defibrillator on Mr Cunningham but could not connect the defibrillator pads to the machine as they did not fit. A second set of pads was obtained, but they did not fit either. However, it was concluded that this failure did not contribute to Mr Cunningham's death. The AGCC defibrillator was being serviced. The supplier had lent the machine used during the incident. Due to the way the pads were packed, it was not obvious that they did not fit the machine until nurses tried to use them to resuscitate Mr Cunningham.

68. I accept the submission from the GEO Group that there is no evidence to suggest that the use of the defibrillator by the nurses would have prevented Mr Cunningham's death. The paramedics who arrived on the scene had a functioning defibrillator. When connected, it advised that defibrillation was not recommended, and CPR was continued by CCOs under QAS supervision.

69. The OCI Report concluded that the primary matter that may have contributed to Mr Cunningham's death was the physical design of the cells in Unit C3 and other units at AGCC. The placement of metal louvre bars at the top of the cell creates obvious hanging points. The risk of prisoners using 'hanging points' such as these to commit suicide is well known.

70. This has been considered in previous coronial inquests, and has been noted as a longstanding (but not fully implemented) recommendation to remove 'hanging points' from correctional centres. The OCI report stated the removal of 'hanging points' would involve significant (and possibly prohibitive) costs, but arguably there should be a greater impetus to remove 'hanging points' at a remand centre such as AGCC.

71. The investigation also noted that AGCC's prisoner population was over capacity at the time Mr Cunningham died, however found no evidence that this contributed to his death.

Office of the Chief Inspector Recommendations

72. A total of four (4) recommendations were proposed by the OCI investigators. I was provided with a statement from QCS Assistant Commissioner Peter Shaddock which advised that AGCC had formalised implementing the OCI recommendations in April 2021. Mr Shaddock's statement set out each recommendation together with the steps taken to implement.[12]

    1. *That the Chief Superintendent, AGCC ensures that the centre has adequate practices in place so that defibrillators and other medical equipment used by QCS staff are regularly checked and confirmed to be working and ready to use.*

73. AGCC has implemented a process to ensure staff check defibrillators on a weekly monthly basis, with a defibrillator check spreadsheet to be maintained.

    2. *That the Chief Superintendent, AGCC ensures that an instruction is provided that requires that all major incident debriefs are undertaken in compliance with related COPD and associated procedures and annexures.*

    3. *That the Chief Superintendent, AGCC instructs staff that when hand-written notes are used to record elements of an incident that they are retained as evidence.*

74. Mr Shaddock's statement indicated that instructions have been provided to AGCC staff in relation to recommendations 2 and 3.

    4. *That the Chief Superintendent, AGCC ensure suitable governance and assurance are in place regarding the assessment, management and recording of the decision-making regarding cell placement of prisoners to minimise the risk of suicide by hanging.*

75. Mr Shaddock advised that AGCC has a process in place to ensure prisoners who are identified as being at risk of engaging in self-harm or suicide are only accommodated in safer cells, which have reduced access to ligature points within the cell. He said that AGCC acknowledges that a particularly high risk time for remand prisoners is the initial period of entry into a correctional centre. To reflect this, all newly admitted prisoners to AGCC must be initially accommodated in safer cells. Prisoners who have been identified as being at risk of engaging in self-harm or suicide should only be accommodated in safer cells where possible.

76. A weekly review of the "New Stock Register" occurs each Friday to ensure there are no at risk prisoners accommodated in unmodified cells that have access to ligature points. Where a prisoner has been inappropriately allocated to an unmodified cell, arrangements will be made to transfer the prisoner to a suitable cell.

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[12] Ex B8.

Conclusions

77. I am satisfied that there was no evidence to indicate that Mr Cunningham expressed an intent to die by suicide prior to his death. I accept that there was no basis upon which prison staff or management could have formed a concern that he was at elevated risk of self-harm. I consider that there were no opportunities for intervention that could have changed the outcome.

78. Mr Cunningham was assessed by a prison psychologist on entry into prison. When he was asked about self-harm, he denied having any thoughts, plans, or intent. Having regard to his history of ADHD and the circumstances of his alleged offending, he was referred by the psychologist to the Prison Mental Health Service. However, he subsequently declined to engage with that service. I accept that this referral did not engage the requirement to place Mr Cunningham on a Self-Harm Episode History flag, which may have resulted in his management under the Elevated Base Line Risk procedure, including placement in safer cell accommodation.

79. Mr Cunningham gave no indication that he found prison life difficult. He was well regarded by other prisoners and had not expressed any concerns about his well-being or any form of suicidal ideation.

80. The phone calls made by Mr Cunningham on the day of his death indicate that he was frustrated and jealous towards his partner. However, by the end of the final call with her he seemed less concerned.

81. The observations of other prisoners indicated that he appeared upset after the phone calls, particularly because his partner was not going to visit him for his birthday and was in Sydney with his male friends. At the time of lockdown that day Mr Cunningham was reported to be 'back to his usual self' and there was nothing about his behaviour that alarmed other prisoners, or caused them any concern.

82. It is reasonable to assume that Mr Cunningham was concerned about the charges he faced. He faced a lengthy period on remand and while there had been several mentions, the proceedings had not reached the committal stage. Though he did not articulate this to other prisoners, or express any thoughts of self-harm, the consensus was that the potential life sentence weighed heavily on him.

83. It is possible that his decision to end his life was an impulsive reaction to the immediate stressors he faced at the time of his death.

Findings required by s.45

Identity of the deceased –	Luke Cunningham
How he died –	In April 2018, Mr Cunningham was remanded in custody on charges that included murder. He had no history of suicidal ideation or mental health concerns in prison. He intentionally took his own life after fashioning a ligature from a prison issued jumper which was tied to exposed metal bars in his cell. There was no evidence to implicate any other person in his death.
Place of death –	Arthur Gorrie Correctional Centre, Wacol Station Road, Wacol, Queensland
Date of death–	15 September 2018
Cause of death –	Hanging

Comments and recommendations

84. Section 46 of the *Coroners Act 2003* (Qld), 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.

85. Having regard to the recommendations made by the investigators engaged by the Office of the Chief Inspector and the QCS response to those, I make no further recommendations about those matters.

86. Mr Shaddock's statement indicated that as at 26 March 2021 there were 340 cells with Queensland waiting to be modified to safer cell status by removing and reducing access to ligature points, including 268 cells at AGCC. The major cost associated with modifications is that exposed bars such as those used by Mr Cunningham provide the only source of ventilation to cell occupants.

87. Air-conditioning would need to be installed to ensure compliance with the National Construction Code of Australia. Mr Shaddock indicated that the refurbishment of cells remains a priority for QCS and forms part of its Strategic Asset Management Plan 2020-2024. Implementation of that strategy is subject to the provision of necessary funding by the Queensland Government.

88. I commented on the ongoing presence of old stock cells at AGCC that do not have safer cell specifications in place in the Inquest findings in relation to the death of SVE.[13] It was recommended in those findings that the Queensland Government publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy. I make no further recommendation on that topic.

[13] https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/684729/cif-SVE-20210524.pdf

89. I extend my condolences to Mr Cunningham’s family and friends. I close the inquest.

Terry Ryan
State Coroner
BRISBANE