CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Cindy Leigh Miller**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO:	2018/1782
DELIVERED ON:	22 January 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 June 2020, 10-11 August 2020
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, police watchhouse, mixed drug toxicity, assessment and monitoring of prisoner health, police CPR skills and training, investigation of police related deaths.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lio Willie
Pat Miller and Tarnii Redding:	Ms Janice Crawford, instructed by Kilroy Callaghan Lawyers
Commissioner of Police:	Ms Maria Vassilakos, Queensland Police Service Legal Unit
Queensland Ambulance Service:	Mr Dev Pillay, Queensland Ambulance Service
Detective Sergeant Findlay Senior Constable Snelling Sergeant Abel Sergeant Ponting Constable Weibel Senior Watchhouse Officer Beckman:	Mr Stephen Hollands

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Introduction

1. Cindy Leigh Miller was aged 44 years when she died in custody at the Ipswich Watchhouse early on 21 April 2018. Ms Miller was found by watchhouse staff in an unresponsive state in a secure cell. As Ms Miller died in police custody an inquest was required by the *Coroners Act 2003*.

2. Detective Sergeant David Findlay of the Internal Investigations Group (IIG), Ethical Standards Command investigated the circumstances surrounding Ms Miller's death.

3. The investigation was informed by statements and recorded interviews with the relevant watchhouse and police officers and Queensland Ambulance Service (QAS) staff. CCTV footage and documentation relating to policies and procedures at watchhouses were also obtained. Forensic analysis was conducted. All police investigation material was tendered at the inquest.

4. A full internal autopsy examination was conducted by Specialist Forensic Pathologist, Dr Rebecca Williams. The autopsy examination found that Ms Miller's cause of death was mixed drug toxicity. Coronary atherosclerosis and hypertension were identified as other significant conditions contributing to her death.

The Inquest

5. A pre-inquest conference was held on 17 June 2020. Leave to appear at the inquest was granted to Ms Miller's mother, Pat Miller, and daughter, Tarnii Redding, and to the Commissioner of Police. Leave was subsequently granted to the Queensland Ambulance Service and the relevant police and watchhouse officers.

6. Following the pre-inquest conference submissions on the proposed issues to be examined at the inquest were made by the Commissioner of Police and Ms Miller's family. The list of issues for the inquest was subsequently settled as:

    1. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death;

    2. The adequacy of Queensland Police Service training, policies and procedures with respect to the remand, intake and assessment of persons to be detained in a watchhouse (including questioning, searching, obtaining of medical and/or health information and monitoring).

    3. The adequacy of emergency procedures at the watchhouse with respect to the:
        - identification and management of prisoner-related medical emergencies;
        - level of CPR training completed by each staff member on shift during Ms Miller's remanded in custody;
        - effectiveness of the staff response to Ms Miller's medical emergency; and

- effectiveness of the duress alarm system.

4. The adequacy of CCTV cameras, monitoring facilities and related policies and procedures during police transport and at the watchhouse.

5. Whether there are ways to prevent a death occurring in similar circumstances in the future.

7. The inquest was held in Brisbane on 11-12 August 2020. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered. Oral evidence was heard from the following witnesses:

- Detective Sergeant Findlay
- Sergeant Gregory Abel
- Constable Troy Snelling
- Sergeant Trisha Ponting
- Senior Watchhouse Officer Graham Beckman
- Constable Michael Weibel
- Inspector Jeffrey Coote
- Inspector Douglas McDonald
- Dr Adam Griffin, Clinical Forensic Medicine Unit.

8. The evidence tendered in addition to the oral evidence was sufficient to make the requisite findings.

The investigation

Personal and criminal history

9. Ms Miller was survived by her three children and her mother. Supreme Court sentencing remarks from 2015 indicate that she had a history of drug abuse and the formation of relationships characterised by drug abuse. Her criminal history commenced in 1994 and was not particularly lengthy, consisting primarily of drug offences[1] and *Bail Act* breaches.

10. An “Intelligence Analysis” was conducted of Ms Miller’s mobile phone which extracted data between 9 February 2018 and 21 April 2018 inclusive. The messages downloaded from her phone indicate that Ms Miller was a regular consumer of drugs, including methylamphetamine and cannabis.

11. There were numerous text messages during this time between Ms Miller and her partner, Mr Hungerford, where she attempted to source drugs from him and referred to “taking a shot” or “hanging for a shot”; as well as references to smoking cannabis.

[1] Ex C7 – Possessing dangerous drugs x 4 convictions; possess utensils x 3; fail to properly dispose of syringe x 2; breach bail x 2; failure to appear x 2

12. Medical records for Ms Miller indicate that she did not have any diagnosed conditions. Her enlarged heart was identified during the autopsy. The last time she attended hospital was in 2014 for a head injury but no other injuries or health concerns were noted. A review of her PBS and Medicare information indicated that she had not made any claims for the 12 months preceding her death.

13. Ms Miller's offending was relatively consistent until she was convicted of manslaughter in 2007 and she was sentenced to seven years imprisonment. That offence appears to have occurred while she was trying to leave a relationship where Ms Miller was subjected to ongoing domestic violence. She was released on parole in 2009 and was subject to that order until 2013. Ms Miller complied for the most part with her parole order. Her breaches were by way of testing positive for cannabis. She was subsequently required to complete drug workshops and was given a formal warning. She was not returned to prison nor did she reoffend during that time.

14. Ms Miller's offending resumed in 2014 and her final conviction was on 1 September 2015 in the Supreme Court at Brisbane for possessing a schedule 1 dangerous drug in excess of 2 grams, and possessing a schedule 2 dangerous drug. She was sentenced to 12 months imprisonment to be served by way of an intensive correction order (ICO).

15. She was inducted into the ICO on same date and attended her initial appointment, where she disclosed that she continued to use "ice" and was smoking cannabis. No immediate risks or needs were identified.[2] Ms Miller failed to report between 25 September 2015 and 1 October 2015.

16. During the short period of Corrective Services engagement with Ms Miller she admitted that she was maintaining her use of methylamphetamine and cannabis. A warrant for her arrest was issued on 16 September 2015 for failure to appear in the Ipswich Magistrates Court in relation to a total of 18 outstanding drugs and weapons offences.

17. During the ICO Ms Miller failed to report on six occasions and failed to attend community service on three occasions. The last contact Probation and Parole had with Ms Miller was on 15 October 2015. Breach action was initiated and on 23 October 2015 and an arrest warrant was issued.[3]

Events leading up to the death

Police interception - 20 April 2018

18. On Friday, 20 April 2018 at approximately 5.30pm, Constables Snelling and Viliamu of the Ipswich Tactical Crime Squad intercepted a Holden Commodore utility for the purpose of a registration and licence check of the driver, Bradley Hungerford, who was Ms Miller's co-defendant in relation to the charges before the Supreme Court in 2015. She was the only other occupant of the vehicle, seated in the passenger seat.

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[2] Ex D1, para. 18

[3] Ex D1, para. 72

19. Ms Miller initially provided a false name which was not recorded in police records. After further questioning Ms Miller provided her correct name and it was identified that she had two outstanding warrants. One was for a failure to appear on 16 September 2015, and the other was a 'First Instance Warrant' issued on 26 October 2015. She was formally arrested. [4]

20. Further computer checks revealed that both Ms Miller and Mr Hungerford had police warnings, flags and extensive criminal histories in Queensland. Ms Miller had a QPRIME warning linked to a drug possession occurrence from 8 May 2015 that stated, ***Secretes Used Needles in Bra***.

21. Ms Miller and Mr Hungerford were detained for the purpose of a vehicle and pat down search. The search of Mr Hungerford and the vehicle did not reveal any items of interest.

22. During the search of Ms Miller's handbag, police located two used hypodermic syringes, several empty small clip seal bags[5] and three Valium tablets in a blister pack. Police waited for a female officer to arrive to the intercept site to conduct a pat down search of Ms Miller. That search located no items of interest.

23. Constable Snelling told the inquest that Ms Miller displayed no overt indicia of drug use when she was arrested. She was coherent and standing. Constable Snelling said that, based on his previous experience, she looked like an amphetamine user because she was very thin with sunken features and was found in possession of used syringes and clip seal bags. She was cooperative during the search of the vehicle and her possessions.

Time in the watchhouse

24. After the conclusion of the search, Ms Miller was transported to the Ipswich Watchhouse in a police wagon (pod).[6] Constable Snelling said that he observed no changes in her demeanour during the transit. He said that he had no concerns for her and that his view was unobstructed, although he had to turn his head to the rear to see her. He observed Ms Miller stay seated in the same position throughout the journey with her back against the rear of the pod facing the front cabin where the two officers were sitting. His evidence was that officers in the front cabin can hear noises and movements from the pod, that the pod was well lit. He could see Ms Miller's face in the rear-view mirror and through the Perspex window. There was no other way of monitoring her during the 15 minutes it took to reach the Ipswich watchhouse.

25. On her arrival at the watchhouse at 6.52pm, the shift supervisor, Sergeant Abel, completed Ms Miller's health questionnaire and assessed her suitability to be held in custody. Ms Miller answered 'yes' to consuming alcohol[7] but denied consuming any illicit substances in the last 24 hours. She also claimed she did not have an addiction or dependency on drugs of any kind.[8] Ms Miller indicated she had a fractured left foot (which was bandaged) and a burn that did not require any medical

[4] Ex G2 - Arrested at 1745 hours

[5] Ex A5, p2 - Analysis of the clip seal bags confirmed trace levels of methylamphetamine

[6] Transported at 6.32pm

[7] Ex C2

[8] Ex C2

attention. Ms Miller could walk without any difficulty. In his evidence, Sergeant Abel said that the Queensland Ambulance Service were not always in attendance at the watchhouse but could be called upon if necessary.

26. Ms Miller was formally processed through the watchhouse at 6.54pm for the two warrants and the two new drug offences. Although the arresting officers had told her they had no objection to bail, Sergeant Abel denied Ms Miller bail because he thought she was at risk of failing to appear. She was remanded to appear in the Ipswich Magistrates Court on Monday, 23 April 2018.[9] Sergeant Abel said that the decision to refuse Ms Miller bail was a judgement call on his part. He said that she was in a show cause situation under the *Bail Act,* and had not been forthcoming in relation to her whereabouts since late 2015.

27. Sergeant Abel told the inquest that there were no observations of Ms Miller that were of concern to him when she arrived at the watchhouse. If there had been, she would have been placed in an observation cell with continuous lighting and observations every 30 minutes. The Queensland Ambulance Service could also have been called. He said that while he was aware of her history of drug use, every second person entering the watchhouse has a similar history.

28. Ms Miller was deemed a "Level 1" prisoner for the purpose of frequency of prisoner inspections. An unclothed (strip) search was conducted which did not locate any items of interest, and she was given watchhouse issued clothing and placed into Bulk Hold Cell 1.

29. At 8.25pm, Ms Miller made a phone call to her mother, Patricia. She told her mother that she was OK, that she had to appear in court on 23 April 2018 and required some additional clothing. After this, Ms Miller was placed in Exercise Yard 5 – Cell 5.1, where she was locked down for the night. She was the sole occupant of that cell.[10]

30. As a 'Level 1' prisoner, checks were required to be conducted of Ms Miller every sixty minutes or less.[11] These were recorded as follows:

Time	**Officer**	**Type of check**	**Result of check**
7:58 pm	AWO Ho	Physical cell check	No complaints. No problems
8:25 pm	AWO Ho	Escorted	Escorted from phone call to cell 5.1
8:52 pm	AWO Sia	View from Pod 2 console – in front of Cell 5	No complaints. No problems detected
9:33 pm	AWO Sia	Physical cell check	No complaints. No problems. Prisoners locked down for night
10:05 pm	AWO Ho	Physical cell check	Ms Miller advised she wanted to go to sleep for the night. Lay down on the cell bench with her head furthest from the cell door
10:45 pm	Const Weibel	Physical cell check	No complaints. No problems detected. **Notes not updated until 11.11pm*

[9] Sergeant Abel was authorised to refuse bail under s16.4.2 'Responsibilities of Watchhouse Manager' OPM. As 20 April 2018 was a Friday and she was remanded until the Court sat again.

[10] Ex C3

[11] Ex A8, B6, B16, B20 and C2

11:50 pm	Const Weibel	Physical cell check	No complaints. No problems
12:41 am	Const Weibel	All Physical cell check	No complaints. No problems detected. Torch shone into cell to confirm signs of life
1:35 am	Const Weibel	Physical cell check	Torch shone on Ms Miller - unresponsive

31. At the inquest Constable Weibel said that no concerns had been relayed to him in relation to Ms Miller at handover. He walked up to the cell door to conduct his cell checks. He said that it was his practice to dim the cell lights as far as possible to allow persons within the cells to sleep but still allow observations to occur. His practice was to look for movements from the person, and he generally took his own torch to work for that purpose. He would observe the person until he could see some form of movement.

32. Evidence was received from Inspector Coote from the Brisbane watchhouse.[12] He said that when a person is brought to the watchhouse they are continuously assessed, commencing from the removal of a person from the police vehicle by the arresting officers, when they are subject to a pat down search.

33. Inspector Coote also said that officers observe a very wide range of indicators in relation to the demeanour and communication of persons admitted to watchhouses. This initially occurs in a front holding cell where they can be observed by the watchhouse officers. At this stage they have not been formally accepted into the watchhouse, in the watchhouse manager can decide at any time to decline to accept the person he or she considers that the person requires urgent or immediate medical treatment.

34. Inspector Coote said that at the first opportunity the arrested person should be removed from the front holding cell and presented to the charge counter to be assessed, formally advised why they are in the watchhouse and have their property documented. The assessment of prisoners takes place in accordance with OPM 16.13.1 with a series of questions about the person's physical and mental health and observations of the person. Receiving officers use a list of questions contained on the police database or the Health Questionnaire and Observations Check List. This is used to elicit responses from the person which are recorded along with any observations. Persons are asked to confirm their responses electronically.

35. Inspector Coote said that the frequency of inspections was determined in accordance with OPM 16.9.5 '*Determining the frequency of prisoner inspections*', and inspection actions are graduated:

- Level 1 – general: 60 minutes or less;
- Level 2 – intermittent: 30 minutes (where the member conducting the checks is to interact with the prisoner);
- Level 3 – medical: As a minimum 30 minutes for the first 4 hours with the results of the 3 stage assessment (open eyes/respond verbally/move limbs) recorded in the detention log; and

[12] Ex B25

- Level 4 – constant: Constant visual supervision in the case were a person in custody has known significant risk factors such as actively attempting self-harm.

36. Inspector Coote confirmed that conducting checks on people, particularly when it involves rousing or disturbing the sleep, can have a detrimental effect on the relationship between watchhouse officers and the person. Persons can interpret constant observations and/or interaction as a form of harassment. A minimum of two watchhouse officers would be required to enter a cell where one person is housed and at least one of these would need to be the same gender as that person. Prisoners are likely to consider such contact intrusive, unnecessary and intimidatory.[13]

37. Inspector Coote said that there was no expectation that police officers would have the skills experience and knowledge to diagnose medical conditions. Questions and observations are obtained during an assessment to determine if a reasonable degree of suspicion exists about the person's health. Where such suspicion exists, the responsible officer is to seek appropriate professional health care assistance or advice. Watchhouse officers are not to accept prisoners who are unconscious or in need of urgent or immediate medical attention. OPM 16.3.1 addresses the prevention of death from drug overdose. The OPM elaborates on symptoms and behaviours of people suffering from alcohol or drug withdrawal or overdose.

Ms Miller's death

38. At a cell check at 1.35am on 21 April 2018, Constable Weibel could not observe any signs of life from Ms Miller. He shone his torch on her and opened the cell hatch door to rouse her. As this was unsuccessful, Constable Weibel unlocked the cell and physically touched Ms Miller. He confirmed that she was unresponsive, although QPS policy was not to enter a cell alone.

39. Constable Weibel alerted the Shift Supervisor, Sergeant Ponting, and activated Ms Miller's cell intercom to communicate with AWO Beckman at the charge counter. AWO Beckman left the intercom open for the duration of the medical response.

Resuscitation efforts

40. When Sergeant Ponting attended, she and Constable Weibel lifted Ms Miller onto the cell floor and commenced CPR.[14] AWO Beckman called '000'[15] and requested for QAS attendance.

41. While waiting for the QAS, Sergeant Ponting unsuccessfully attempted to locate a manual resuscitation mask. The watchhouse defibrillator was then obtained by Sergeant Ponting, and alongside two other officers they followed the audible instructions which ultimately advised the officers not to shock Ms Miller but to continue CPR.[16] Sergeant Ponting's evidence at the inquest was that Ms Miller displayed no signs of life from the time she entered her cell. On her view, Ms Miller was deceased well before 1.43am.

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[13] EX B 2 5

[14] First Aid commenced at 1.38am

[15] Phone call made at 1.39am

[16] The underlying cardiac rhythm was either asystole (no electrical activity) or PEA (pulseless electrical activity). In those circumstances survival rates vary between 0-5%.

42. The first QAS advanced care paramedic unit entered Ms Miller's cell at 1.47am. They observed a female QPS officer performing CPR. The paramedics advised her that she needed more depth in performing CPR. An oropharyngeal airway was inserted, and paramedics used a bag-valve-mask to provide ventilation. An electrocardiograph was obtained and revealed pulseless electrical activity at a rate of 30 complexes per minute, ultimately degenerating into nil cardiac electrical activity.

43. The second QAS unit to arrive at the watchhouse was slightly delayed because the roller-door to the watchhouse would not remain open. The exercise yard doors also were not initially open for the paramedics.[17] Once they were able to access Ms Miller, she was moved from the cell into the exercise yard to allow easier access for resuscitation. Resuscitation efforts continued until 2.09am, and a life extinct certificate was issued at 2.10am.

44. A forensic search was conducted of the three cells Ms Miller occupied during her time at the watchhouse and no items of interest were located.

45. Advanced Care Paramedic Ivana Dragic stated that she advised the female QPS officer of some minor changes to her CPR technique, to have more depth in her compressions. Notwithstanding, she considered that the CPR being applied by the QPS officers was effective.

46. Copies of the training history of all watchhouse staff who worked during the relevant afternoon and evening shifts on 20 April 2018 were obtained and revealed that only three of the ten staff rostered that day had completed first aid or CPR training.[18] Those three officers completed CPR training in September and November 2017.[19]

47. From the time of Ms Miller's death until 19 August 2019, only one of the watchhouse officers had completed first aid training.

48. Constable Olver also commented that the defibrillator leads were not connected to the unit at the time they tried to use it on Ms Miller, and it took them a couple of seconds to realise that and once they did realise that the leads needed to be plugged in, the defibrillator started working.[20] Acting Inspector Riznyk, responded to this concern by email stating:[21]

> *There are no external power leads attached as it is powered by an inbuilt battery with a minimum of a 2 year life span. The device is just over 1 year old. The device is self- explanatory in its use when turned on by audio and digital instructions. All WHouse staff are aware that it is available for use when required.*

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[17] Ex E9, para. 6

[18] Ex C16 – C25

[19] Ex C17, C18, C23

[20] Ex B13

[21] Ex C28

49. Inspector Coote said that watchhouse officers have the same level of first aid training as general duties police. Watchhouse officers must be current in their operational skills and tactics training, and trained in the use of first aid and resuscitation equipment provided. They do not have to be qualified in first aid or CPR but will have been first aid and CPR qualified at some time in their career. He said that in the first instance QAS intensive care paramedics were the most appropriate professionals to provide immediate medical assistance to persons detained in the watchhouse. Where immediate assistance is not required, watchhouse officers can contact a Government Medical Officer, hospital or the Clinical Forensic Medicine Unit.

OPPORTUNITY TO CONSUME DRUGS

50. Mr Hungerford was reluctant to provide a statement to police about his relationship with Ms Miller or provide information about their activities in the days leading up to her death.[22]

51. As noted previously, Ms Miller was coherent and cooperative at the time of her arrest. Officers involved in the arrest and watchhouse staff observed no indicia that Ms Miller was under the influence of drugs or alcohol.

52. Dr Ian Home from the Clinical Forensic Medicine Unit (CFMU) was contacted by the IIG and asked whether it was possible to determine a timeline for Ms Miller's consumption of drugs to the time of her death. Dr Home's response explained that the CFMU cannot perform a countback on methylamphetamine in the same way as alcohol as there were too many variables:

> *Even the level detected after death may not reflect the level prior to death due to a phenomenon referred to as post-mortem redistribution. It is not uncommon for the post-mortem level to be double what it would have been just before they died. If we halve the detected, 2.2mg/kg is still a very high level. Having said that, we have seen drivers with very high levels that appear relatively fine.*
>
> *Whilst it is possible Ms Miller had an extremely high level when first detained and died from its toxic effects more than six hours later, the more logical explanation would be that she either deliberately ingested methylamphetamine whilst in custody or the clipseal bag discovered in her vagina failed and it was absorbed that way.*

[22] Ex C10, P8

53. While it is possible that Ms Miller deliberately ingested methylamphetamine while she was in custody in the watchhouse there is insufficient evidence to reach that conclusion. Her movements upon arrival at the Ipswich Watchhouse were:[23]

Time	Movement / location
6:33 pm	Placed in Hold Cell 2 and she lay down on the bench
6:49 pm	Taken to the charge counter
6:54 pm	Strip searched by AWO Ho. Given prison greens to wear
6:56 pm	Placed in Bulk Hold Cell 1
8:10 pm	Removed from Bulk Hold Cell 1
8:25 pm	Allocated to Cell 5.1 and placed into Yard 5. She was the only occupant in this cell. Ms Miller went straight into the cell and made herself a bed on the bench and lay down. She told officers she wanted to sleep. Once Ms Miller lay down, she did not get up from the bench.
11:58:24 pm	The last physical movement can be seen on CCTV

54. CCTV footage shows that the only opportunity Ms Miller had to consume any concealed drugs was when she was in Bulk Hold Cell 1 for 1 hour and 15 minutes. Ms Miller was the only occupant in this cell. The CCTV camera is located to the left of the entrance door, a point of view from the bottom left of screen. At the top right of the screen is the privacy screen shielding the toilet.

55. Inspector Coote said that CCTV cameras do not replace the need for personal observation and inspection of people, particularly while the person is sleeping or not moving, and their breathing and other small movements cannot be observed via CCTV. A thin polycarbonate sheet (Lexan) is used to protect cameras but can be obscured or damaged by smearing, scratching all or covering with foreign objects.

INTERNAL INVESTIGATIONS GROUP INVESTIGATION FINDINGS

Treatment of Ms Miller after arrest

56. The Internal Investigations Group investigation concluded that Ms Miller was lawfully arrested on outstanding warrants together with offences relating to the possession of drugs and drug utensils.

57. The initial interaction with Ms Miller following the interception of the Commodore utility was captured on body worn camera. While Ms Miller initially provided a false name to police, she was cooperative with the officers throughout the roadside intercept and later when she was processed through the watchhouse. The investigation found that the officers treated her with respect.

Unclothed search

58. When Ms Miller was being processed through the watchhouse a female watchhouse officer conducted an unclothed search. This involved Ms Miller firstly running her fingers through her hair, opening her mouth, removing her top and bra. Ms Miller was then given a green watchhouse shirt to wear. Ms Miller removed her shorts and underwear.

[23] Ex G12

59. AWO Ho did not observe any items on Ms Miller's body, nor did she receive any indication Ms Miller had anything concealed in her vagina.[24] She was then given shorts and tracksuit pants to wear.

60. AWO Ho explained that watchhouse staff have no authority to physically touch prisoners during an unclothed search, or make prisoners squat. AWO Ho commented that even if they had authority to make Ms Miller squat it would not necessarily result in the clipseal bag concealed in her vagina being detected.

61. Inspector McDonald said that officers conducting such searches must comply with section 630 of the PPRA and consider the human rights of person being searched.

Frequency of prisoner inspections

62. At the time Ms Miller was assessed, she was deemed as a "Level 1" prisoner. This required normal prisoner inspections to occur at varying intervals every hour, or less.[25] After reviewing the log of inspections, the Internal Investigations Group investigation concluded there were no issues with the classification, or the frequency of checks conducted on her.

Quality of CCTV

63. The CCTV footage from the watchhouse cells was of poor quality. The footage in the bulk hold cell is clearly visible but was not a sharp picture. The footage from Cell 5 was difficult to view. The footage was grainy, and it appeared the Lexan was scratched or dirty as it was difficult to see Ms Miller as she lay on the bench in the cell.

64. Significant bodily movements such as rolling over or moving her legs could be seen not more subtle movements such as the chest rising and falling, to indicate breathing. This was confirmed at the inquest in the evidence of Sergeant Ponting and Watchhouse Officer Beckman.

65. The poor quality of the CCTV was identified during the IIG investigation. It was thought that the blurry camera vision was caused by grime or spider webs and a clean of all the cameras at the watchhouse was requested. It was later found Cell 5.1 camera had a scratched Lexan that was replaced by a QPS contractor on 21 November 2018.[26]

66. On 26 April 2018, it was advised that the cleanliness of the CCTV cameras would be addressed by the OIC of Ipswich Watchhouse as a result of a recent external inspection conducted during a Health and Safety Management System Targeted Audit concerning the cleaners performance in the watchhouse. It was noted during the audit that the cameras required more regular cleaning as part of the cleaner's functions.[27] The performance of the cleaners was to be monitored by the watchhouse OIC.

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[24] Ex B6

[25] Ex A8, p6

[26] Ex A8, p.91 – 7 months after Ms Miller's death to realise it was a damaged camera lens seems insufficient

[27] Ex C28

67. The QPS allocated recurrent funding of $2 million to the capital works CCTV program from 2010. The purpose was to upgrade the CCTV recording systems so that all watchhouses in Queensland had the same standard. Inspector McDonald said that there are 147 cameras installed at the Ipswich watchhouse that comprehensively cover the facility. Maintenance requirements are reported to Property and Facilities Management, who will engage with contracted security providers for the watchhouse. Scheduled maintenance is undertaken on a six monthly basis with checks covering cleaning, checking focus and confirming capacity.[28]

Watchhouse staff training

68. The IIG investigation concluded that QPS and QAS officers made all attempts to provide medical attention to Ms Miller but were unable to revive her. The watchhouse CCTV footage was reviewed and no suspicious circumstances were identified.

69. Detective Sergeant Findlay acknowledged that, having regard to the method Ms Miller used to conceal the clipseal bag on her person, current policy and procedures made it virtually impossible to locate the clipseal bag without her cooperation and compliance during questioning by QPS officers. She was questioned at the roadside by the arresting officers, during the pat down search, during processing at the watchhouse and during the unclothed search. At no time did she disclose she had concealed drugs on her person.[29]

70. Evidence was also heard at the inquest from Inspector Douglas McDonald from the Ipswich District, Southern region. Inspector McDonald described the online training available to watchhouse officers in relation to Custody Management and Watchhouse Custody, a namely Custody Management (QCO185) and Watchhouse Custody (QCP009). Although the Operational Procedures Manual indicates that watchhouse officers 'should' complete these modules, Inspector McDonald has mandated the completion of QCO185 for all officers performing duties in the Ipswich watchhouse.

71. The IIG investigation did not reveal anything to suggest misconduct or breaches of discipline by any member of the QPS. The investigation determined that police associated with Ms Miller prior to and during her time in custody at the watchhouse complied with policy and procedures and should not be subject of any criminal or discipline action. I accept that conclusion.

[28] Ex B26

[29] Ex A8, p. 94

Autopsy results

72. An external and full internal examination of the body was performed by experienced Forensic Pathologist, Dr Rebecca Williams, on 24 April 2018 at Queensland Health Forensic and Scientific Services. A toxicology screen and CT scans were also undertaken.

73. The external examination showed signs of recent resuscitation efforts and some recent minor injuries on the limbs of no significant. A clipseal bag containing a small crystalline 'rock' was retrieved from the vagina. This crystalline substance was later analysed and confirmed to weigh 8mg, comprising 5mg of pure methylamphetamine. The inner surface of the clipseal bag above the closed seal was analysed, and methylamphetamine was detected.

74. The internal examination showed the heart to be enlarged, with concentric left ventricular hypertrophy, typical of hypertension. There was also severe coronary atherosclerosis, for which hypertension is a risk factor. These abnormalities could have caused death at any time.

75. Toxicology testing indicated that Ms Miller had a lethal combination of substances in her system, which were responsible for her death:

    - amphetamine, at a concentration within a toxic range;
    - methylamphetamine, within a potentially fatal range;
    - ephedrine/ pseudoephedrine, present at non-toxic concentration;
    - paracetamol, within the usual therapeutic range;
    - tramadol, within the usual therapeutic range;
    - cannabis, derivative present.

76. Dr Williams concluded that the cause of death was mixed drug toxicity. She also commented that coronary atherosclerosis and hypertension are significant conditions contributing to death as it would have increased her vulnerability to toxic drug effects.

Findings required by s. 45

77. 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. After considering all the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased – Cindy Leigh Miller

How she died – Ms Miller had a clip seal bag containing methylamphetamine concealed within a bodily cavity following her arrest and remand in custody. It is not clear whether Ms Miller died from an accidental overdose after intentionally consuming the methylamphetamine in custody or inadvertently absorbed the drug from the clip seal bag while she slept in her cell. It is most likely that the fatal quantity of drugs entered Ms Miller's system while she was in police custody at the Ipswich watchhouse. Ms Miller was subject to hourly checks of her welfare. She was not found unresponsive until well over an hour after she stopped making overt movements.

Place of death – Ipswich Watchhouse, Ellenborough Street Ipswich, Queensland

Date of death– 21 April 2018

Cause of death – Mixed drug toxicity

Conclusions on other issues

The adequacy of Queensland Police Service training, policies and procedures with respect to the remand, intake and assessment of persons to be detained in a watchhouse (including questioning, searching, obtaining of medical and/or health information and monitoring)

78. I conclude that the relevant parts of Chapter 16 of the Operational Procedures Manual with respect to the care of persons in custody were generally adequate and appropriate and were complied with by the watchhouse manager and relevant QPS officers.

79. I have had the benefit of the body worn camera and CCTV footage recording Ms Miller's interaction with the respective police and watchhouse officers. She appeared to be coherent and cooperative. This footage corroborated the evidence of the officers that there were no indicia before Ms Miller went to sleep that she was under the influence of any substance or required a medical assessment.

80. Having regard to Ms Miller's criminal history and QPrime flag that she secreted syringes in her bra, it was appropriate in the circumstances to conduct an unclothed search. However, there was nothing about Ms Miller's behaviour that justified an application for an invasive search to be conducted of her.

81. Watchhouse staff and police officers do not have the authority to physically touch prisoners during an unclothed search but they can ask a prisoner to squat. However, that would not necessarily have led to the detection of the clip seal bag that she had concealed.

82. No adverse comment is warranted about the conduct of individual officers with respect to Ms Miller's intake and health assessment.

83. Given the assessment of Ms Miller upon her intake into custody there was no reason for her to be monitored any more closely or regularly than the hourly cell checks she was subject to. It appeared that Ms Miller went to sleep once she went into her cell and the lights were dimmed.

84. Constable Weibel was an experienced officer who had worked at the watchhouse for over five years. He said that he stood at the cell and observed Ms Miller until he saw signs of life at his penultimate cell check at 12.41am. By that time, she had been observed eight times over a period of five hours.

85. However, after reviewing the CCTV footage from Ms Miller's cell, I accept the submission of the family but there were no obvious movements made by Ms Miller after 12.03am and that she was likely deceased from that time. In those circumstances I accept the submission from the family the identification of Ms Miller as a prisoner who was medically compromised was missed at the 12:40am cell check. Officer Weibel stayed at the door of the cell for around 12-15 seconds and satisfied himself that Ms Miller was asleep after shining a torch on her. In my view, that was a mistaken belief.

86. I appreciate that intrusive physical monitoring such as entering the cell (which must be done in the company of another officer for safety), turning lights on or trying to rouse prisoners would not generally be reasonable or appropriate in the context of watchhouse custody, taking into account the safety of prisoners and watchhouse officers and prisoners' rights to enjoy a reasonable sleep during the night.

87. While I accept the family submission that cell check officers should be required to ensure that prisoners who appear to be asleep (and are not otherwise moving) are actually breathing by observing a steady rise and fall of the chest, I consider that this issue is sufficiently addressed by OPM 16.13.13 which requires:

> *The inspection officer is to:*
>
> *…*
>
> *(v) ensure a sleeping prisoner is breathing comfortably and appears well;*
> *(vi) wake a sleeping prisoner when the inspecting officer is unsure or has a reasonable degree of suspicion about the condition of that prisoner; and*

88. It was also submitted by Ms Miller's family that the procedure for the assessment of Ms Miller on entry to the Ipswich watchhouse was inadequate. However, the family also acknowledged that she had not been completely truthful when answering questions, and that there were no indicia of intoxication when she was assessed by Sergeant Abel. The family also did not wish to criticise any watchhouse staff in relation to their assessment or management of Ms Miller.

The adequacy of emergency procedures at the watchhouse

89. At the time of Ms Miller's death, only three of the 10 staff rostered on the afternoon and evening of her intake to the watchhouse had completed first aid or CPR training in the period between July 2017 and the date of Ms Miller's death.

90. Senior Constable Mare, who was assisting with CPR but was not stationed at the watchhouse,[30] was advised to increase the depth of her chest compressions by Advanced Care Paramedic Dragic. However, ACP Dragic's evidence was that that the CPR being administered was still effective.

91. Inspector McDonald's evidence was that there is no mandatory set quota for police and watchhouse officers to have completed first aid training other than what is outlined in OPM 16.21.3. That section is broad in nature and requires officers to have completed first aid training and training in different equipment. This was said to encompass all watchhouses from single cells to those in large metropolitan areas.

92. Inspector McDonald's evidence was that there are two first aid training courses in the QPS. The first is *Provide CPR* which requires a 12 month requalification and must be delivered by a recognised provider, such as St John Ambulance or the QAS. The second course is *Provide First Aid* which requires a three yearly refresh to remain current.

93. The statement from Senior Sergeant Kitching, the Officer on Charge of Ipswich Watchhouse, confirmed that an audit of the staff training records was conducted shortly after Ms Miller's death. This revealed that some staff had lapsed in the CPR component of their training. As a result, training for all staff to become compliant was immediately carried out and maintained. Furthermore, training at the Ipswich watchhouse is now under constant review. The Senior Watchhouse Officer now enrols all watchhouse staff in the requisite QPS training courses and records their completion. Senior Sergeant Kitching reviews this record quarterly.

94. Senior Sergeant Kitching indicated that the lapse in maintaining training was a product of the rotation of acting officers in charge at the watchhouse for a period of at least nine months.

95. In terms of the emergency response, the inquest heard from Constable Weibel that he made the decision to enter Ms Miller's cell on his own to assess whether she was alive. He said that he activated the intercom but also called out to Sergeant Ponting as he thought it would be quicker to call for assistance and was not sure that the intercom was operating. There was no other duress alarm system within the watchhouse.

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[30] SC Mare attended the watchhouse following the arrest of another prisoner.

96. The evidence of Sergeant Ponting was that Ms Miller already appeared deceased by the time she was found. Notwithstanding, officers commenced CPR and called for QAS attendance. Officer Beckmann kept the intercom open so that he could efficiently relay information to the QAS. After failing to locate a resuscitation mask to support Ms Miller's airway, Sergeant Ponting retrieved the defibrillator which was approximately 15m away from Ms Miller's cell.

97. It was apparent from the evidence was that there was a lack of awareness by officers on duty of where resuscitation masks and face shields were kept in the watchhouse. At the time of Ms Miller's death these items could not to be located and were not easily accessible in an emergency.

98. The family submitted that cell check officers should carry duress alarms or radios to avoid delays where intercoms may not work. The family also noted that none of the officers who provided assistance had current CPR competency, and submitted that familiarity with all emergency equipment and supporting an airway as a principal component of CPR should form part of annual CPR competency training.

99. While the family accepted that Ms Miller was deceased when CPR efforts commenced, they submitted the response to Ms Miller's medical emergency was not effective for the following reasons as officers:

- Did not check that her airway was clear;
- Did not check that she was breathing;
- Did not check for a pulse;
- Did not have a resuscitation mask;
- Failed to support breathing;
- Were not familiar with the use of the defibrillator.

100. I agree with the submission that Ms Miller's airway was not adequately managed for the period from when CPR commenced to the arrival of the QAS due the absence of resuscitation masks.[31] I also agree that officers were not familiar with the operations of the defibrillator. However, the evidence supports that officers were mindful of the need to maintain her airway but were hampered by lack of access to appropriate respiration masks.

101. The family submitted that CPR emergency equipment should be stored within a defined place within the watchhouse and should be accessible with a minimum amount of delay with daily checks of items which are replaced as required and subject to a quarterly audit.

102. I accept the evidence of Constable Weibel and Sergeant Ponting was that following Ms Miller's death the management of emergency equipment is a risk management task for a designated watchhouse officer to ensure that the equipment is located where it is meant to be stored and is in working order. I also note that OPM 16.21.8 envisages the use of personal duress alarms for use in watchhouses. I consider that the allocation of such alarms should be considered on a watchhouse by watchhouse basis.

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[31] The QAS' Clinical Practice Procedures for CPR indicate there should be two ventilations for every 30 chest compressions.

103. The family also submitted that all 24-hour watchhouses should have rostered health professionals on site. I am not persuaded that the permanent allocation of QAS staff in watchhouses would be a sound use of resources. The evidence established that the QAS arrived at the watchhouse within four minutes of the call for service. Dr Rashford's evidence was that the QAS has an officer stationed within the Ipswich watchhouse each Friday and Saturday night.

The adequacy of CCTV cameras, monitoring facilities and related policies and procedures during police transport and at the watchhouse.

104. At the time of Ms Miller's admission to custody there was a scratch on the polycarbonate Lexan around the CCTV camera in her cell. It also appeared to be smudged or dirty. The CCTV footage did not capture the rise and fall of Ms Miller's chest. Witnesses confirmed that the quality of the recorded images was the same as the vision on the monitors in the watchhouse. The quality was sufficient to capture significant movements or overt acts.

105. I accept that CCTV visions is not a substitute for regular and close personal monitoring and that watchhouse officers are not able to constantly watch the CCTV. However, as the family noted sufficiently clear footage may trigger a further inquiry in relation to a prisoner who has not moved for a lengthy period.

106. I am satisfied that the issue with the cleanliness of the CCTV cameras in the Ipswich watchhouse has since been rectified with regular cleaning, following an audit of the CCTV cameras in the watchhouse. The scratched Lexan on the CCTV camera in cell 5 was replaced on 21 November 2018.

Comments and recommendations

107. Detective Sergeant Findlay made two recommendations which were explored at the inquest:

- *Prisoners with an extensive drug history who are refused bail should be provided an approved confidential phone call to a medical person with a view to disclosing any drug use or associated medical conditions. The medical person then determines whether to disclose to watchhouse officers in order to appropriately monitor prisoners. Such information could not be used in criminal proceedings.*[32]

- *Consideration should be given to the introduction of requiring prisoners to provide a saliva analysis drug test when entering the watchhouse.*

108. After hearing evidence about the possible implementation of those recommendations from Inspector Coote from the Brisbane watchhouse, Inspector McDonald from Ipswich, and Dr Adam Griffin from the Clinical Forensic Medicine Unit within Queensland Health, I am not persuaded that they should be supported.

109. With respect to providing prisoners the opportunity to make a confidential phone call to a medical person to disclose drug use or other conditions, Inspector Coote

[32] Ex A8, p. 95. Para.

questioned whether persons in custody would be willing to provide this information. Where such disclosure took place there were issues in relation to whether information might be shared with a third party if given to a medical practitioner in confidence. In addition, he said that a person's demeanour and presentation following a physical and visual assessment were more reliable than self-disclosure. He noted that the Australian Institute of Criminology survey of drug use at the Brisbane watchhouse found that over 50% of persons in the watchhouse tested positive for methamphetamine and that regular drug users can develop a high tolerance to drugs.

110. Dr Griffin noted that there remains a current threshold of 'concern' at which a watchhouse officer may determine to refer the person for clinical assessment. This threshold is set at a low level as there is no expectation that a watchhouse keeper act as or stand in for a clinician. He noted that a telephone call is not likely to add enough information, or alleviation of concern, to offer reassurance in relation to the person's wellbeing.

111. Dr Griffin also noted that saliva tests are not representative of blood levels. For example, THC appears on saliva tests because it has recently been used and is present in the mouth: it is not excreted from blood into the saliva. Methylamphetamine also tests without a relationship to the blood level. The test is not a quantifiable test - it would test positive or negative. The test alone cannot confirm the quantity, time of consumption and the level of effect on an individual.

112. Dr Griffin said that how such information would inform care is difficult to understand. Those who use drugs experience difficulty while intoxicated and when withdrawing. Patterns of use vary greatly between individuals. He noted that an approach along the lines of universal precautions whereby every patient is a drug user (given the high percentage currently detected) is likely unconsciously followed already by watchhouse staff.

113. While the family acknowledged that prisoners may not always provide truthful answers, they submitted that prisoners in watchhouse custody should be given an opportunity to speak to a medical professional or another agency such as Murri Watch or Sisters Inside before responding to health-related questions. However, OPM Chapter 16.21.9 already provides that the

...

> *'watchhouse manager is to, subject to operational and/or security needs of the watchhouse, and where appropriate with the consent of the prisoner permit a prisoner reasonable access to a telephone to contact a solicitor, medical practitioner, a friend or a relative as soon as practicable'.*

114. Ms Miller was given the opportunity to contact her mother before 9:00pm on the night she was taken into custody. She told her mother that she was going to be in the watchhouse over the weekend, that she would be taken to court on Monday and needed her mother to drop in some clothes for her. At that time, there were no indications that she was heavily intoxicated or suicidal.

115. As someone who was familiar with the criminal justice system, it is reasonable to assume that Ms Miller would have been aware that disclosing she was in

possession of a schedule 1 drug would result in further charges. It is likely that she did not disclose or dispose the drugs in her possession before entering custody given the initial indications from the arresting officers that she would be granted bail. Some onus must be placed on persons being held on remand to disclose they are secreting a substance or have consumed such.

116. The evidence of Inspectors Coote and McDonald was that there is no script provided for the use of officers administering the health questionnaire. However, persons are told it is for their own health and safety in order to be monitored appropriately in the watchhouse. While officers cannot lawfully provide an indemnity, it is not specifically for the purpose of securing further criminal charges.

117. However, the family submitted that prisoners do not appreciate that health questions are asked for their own benefit rather than as part of a police investigation. In order to prevent future deaths in like circumstances, it was submitted that the medical checklist should be amended to include a script for all admitting watchhouse officers to follow. The script would inform prisoners that the purpose of the medical questionnaire is to assist watchhouse officers to ensure an individual prisoner's health needs can be adequately managed in the watchhouse, and that the responses to those questions will inform watchhouse officers of possible risks that might be known to the prisoner associated with their health while in custody. This should include an assurance to the prisoner that further charges would not result from their truthful answers to the questions.

Recommendation 1

I recommend that the Queensland Police Service consider revising the script that accompanies health questions asked on entry into watchhouse custody with a view to ensuring that prisoners understand that their answers are for the purpose of ensuring their health needs can be managed in the watchhouse. This should include an assurance to the prisoner that further charges would not result from their answers to questions about past consumption of drugs.

118. The evidence at the inquest has established that where there were inadequacies at the Ipswich Watchhouse at the time of Ms Miller's death, those issues have been addressed. Those issues included the lack of currency with CPR training, CCTV camera maintenance and the management of emergency devices in the watchhouse. In those circumstances, I do not consider that there are any further recommendations that I can usefully make on those matters.

119. The family also submitted that the process for the investigation of police related deaths was an area that would warrant comment, and that an independent body should be set up to review critical incidents that occur in police custody in order to satisfy community expectations of independence.

120. This issue was the subject of consideration by the Queensland Government following the Inquest into the death of Mulrunji. In his May 2010 findings, Deputy Chief Magistrate Hine recommended:

That the future investigation of deaths in police custody, which exhibit indicia of unnatural causes or which have occurred in the context of police actions or operations be undertaken solely or primarily by the CMC [Crime and Misconduct Commission], as the specialist misconduct and anticorruption body for the State of Queensland. To enable this to occur, I recommend that the CMC be resourced and empowered (by legislative fiat) to undertake the role.

121. The Queensland Government response to that recommendation records that the recommendation was agreed to in part and implementation is complete.[33] The Government response notes that the Crime and Corruption Commission (CCC) can only exercise legislative powers over police where there is a suspicion of corrupt conduct or police misconduct.

122. The Government response also notes that CCC oversight of the investigation of police-related deaths is focused on the sufficiency and probity of the initial investigative response, and making preliminary determinations about the likelihood of the death involving suspected corrupt or criminal conduct.

123. The current arrangements for the investigation of police-related deaths are underpinned by a 2019 Memorandum of Understanding between the State Coroner, the Commissioner of the QPS and the Chairperson of the Crime and Corruption Commission. The arrangements are also reflected in relevant part of the QPS Operational Procedures Manual, including Chapters 1.16 and 16.23.

124. Chapter 16.23.3 requires that a death in custody is to be treated as a homicide until otherwise determined and officers are not to presume suicide or natural death regardless of whether it may appear likely.

125. The MOU reflects that statutory responsibility for the investigation of police related deaths in custody is not vested in the QPS but in the State Coroner and Deputy State Coroner by the *Coroners Act 2003.*

126. The State Coroner relies on the assistance of the Commissioner under s 794 of the *Police Powers and Responsibilities Act 2000* to ensure that these deaths are independently and impartially investigated by the QPS Ethical Standards Command.

127. The QPS investigation is subject to the oversight of the CCC. CCC officers will generally attend at the scene of a police-related death with ESC officers and will review the completed investigation report to ensure the sufficiency and probity of the investigative response. In my view the CCC performs its oversight functions diligently and effectively.

128. While the QPS investigation report comprises a significant aspect of the coronial investigation, as this inquest has demonstrated, a coroner is not bound to adopt the conclusions or recommendations made in that report. Where appropriate, a coroner will also engage experts external to the QPS to provide opinions on the relevant issues. Persons given leave to appear can also make submission about the issues for inquest, and the witnesses and evidence required.

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[33] https://www.justice.qld.gov.au/__data/assets/pdf_file/0007/597985/qgr-mulrunji-20190212.pdf

129. An inquest is part of the coronial investigation and provides an opportunity for the investigating officer to be questioned about their findings. Each involved officer can also be questioned about their actions by counsel assisting and any person given leave to appear.

130. While from my perspective the current arrangements for the investigation of police related deaths are generally effective, I acknowledge that community confidence in the independent investigation of police related deaths is a matter of significant public interest.

131. On 17 June 2020, the NSW Parliament established a Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody. That Committee is scheduled to report on 31 March 2021. The Committee is examining the suitability of the oversight bodies tasked with inquiries into deaths in custody.

132. To avoid the consequence of diminishing the timely and thorough investigation of police-related deaths, any changes to the current arrangements in this State would require a very detailed consideration of which entity is best placed to assist the coroner in the independent investigation of these deaths, the oversight required, with associated investigative powers provided for in legislation and necessary resources allocated.

Recommendation 2

I recommend that the Queensland Government consider whether to commission an independent review of the current arrangements for the investigation of police-related deaths on behalf of the coroner and the oversight of those investigations.

133. Finally, I extend my condolences to Ms Miller's family and friends. It was clear from the evidence that she was loved and is deeply missed by them. I close the inquest.

Terry Ryan
State Coroner
BRISBANE