QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Edward Harris**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO(s):	2019/2961
DELIVERED ON:	20 September 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 August 2021, 13 September 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, suicide, death in custody, hanging, life prisoner, hanging points.

REPRESENTATION:

Counsel Assisting:	Ms Melia Benn
Queensland Corrective Services:	Ms Jesika Franco, Crown Law, instructed by Ms Megan Lincez (QCS)

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Introduction

1. John Harris was aged 47 years when he was found deceased in the Harold Gregg Units at Townsville Correctional Centre (TCC) early on 4 July 2019. Mr Harris was serving a life sentence for murder when he was found hanged in his cell.

2. Two letters were found in Mr Harris' cell which indicated he had been contemplating suicide for months before his death.

The investigation

3. An investigation into the circumstances surrounding Mr Harris' death was conducted by Detective Senior Constable Peta Schenk of the Corrective Services Investigation Unit (CSIU).

4. The investigation concluded that there were no suspicious circumstances surrounding the death, and that the death was not preventable as all Queensland Corrective Services policies were followed.

5. After being notified of the death, detectives from the Townsville CIB went to TCC together with a scenes of crime officer. Other prisoners were already locked down in their cells. A search of the cell revealed no suspicious circumstances. A fingerprint examination confirmed Mr Harris' identity.

6. Detective Senior Constable Schenk later obtained prison and medical records relating to Mr Harris. CSIU officers conducted interviews with other prisoners in his unit at TCC. Statements were also obtained from Corrective Services staff and Mr Harris' mother and partner, Linda Appleton.

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

8. Inspectors appointed by the QCS Chief Inspector under the *Corrective Services Act 2006* also investigated Mr Harris' death and prepared a report which was tendered at the inquest.

The inquest

9. Mr Harris was a prisoner in custody at the time of his death, as defined in Schedule 4 of the *Corrective Services Act* 2003. Pursuant to section 8(3)(g) of the *Coroners Act 2003,* Mr Harris' death was a 'death in custody' and an inquest was required.

10. The inquest was held at Townsville on 13 September 2021. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence.

11. The issues considered in the inquest were the findings required by s45(2) of the *Coroners Act 2003*, 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.

12. In addition to DSC Schenk, the inquest heard from Custodial Corrections Officer (CCO) Dion Forman and QCS Assistant Commissioner, Peter Shaddock.

The Evidence

Personal History

13. Mr Harris was born in Brisbane on 22 March 1972. His mother recalled that he was a 'good kid who was kind, family orientated and did well in school'.[1] Mr Harris resided with his mother until he went to prison, where he spent most of his adult life.

Criminal History[2]

14. Mr Harris had an extensive criminal history that commenced when he was aged just 11 years. He was sentenced to his first term of imprisonment when he was convicted of offences of violence when aged 20.

15. On 20 October 1999, Mr Harris was found guilty of manslaughter and was sentenced to 10 years'[3] imprisonment that was to be served cumulatively to sentences he was already serving for drug and property offending. His sentence effectively was 12 years and 3 months. It was noted during the sentencing hearing that Mr Harris was a long-term amphetamine abuser.

16. Mr Harris was later sentenced for other matters committed prior to the manslaughter offence as well as other offences committed while in prison.

17. On 21 October 2016, Mr Harris was sentenced to life imprisonment for the offence of murder. On the fifth day of the trial Mr Harris and his de facto partner, Ms Linda Appleton, pleaded guilty to murder and several other associated offences including deprivation of liberty and drug trafficking.

18. On 16 June 2014, Mr Harris and Ms Appleton killed Ms Tia Landers, who Ms Appleton had accused of having an affair with Mr Harris. The offence involved the "protracted, sadistic and brutal" torture of Ms Landers over a period of hours.[4] Mr Harris then shot Ms Landers and her body was buried in a shallow grave in the Beerburrum forest.

19. Mr Harris was not eligible to apply for parole for 27 years, which placed his parole eligibility date in 2041.

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[1] Exhibit B6.
[2] D1 and *R v Harris* [2000] QCA 217.
[3] As he was sentenced to 10 years imprisonment the offence was automatically declared a serious violence offence and he had to serve 80% of that 10-year sentence.
[4] Sentencing remarks

20. The fifth anniversary of the date that Mr Harris and Ms Appleton were remanded in custody for the charge of murder was 3 July 2019. Mr Harris was found deceased in his cell the next morning – 4 July 2019.

Medical History

21. Mr Harris was diagnosed with epilepsy in 2001[5] and this condition was being managed in prison. There are frequent references to Mr Harris having epileptic episodes throughout his records, including staff observing that Mr Harris had bruises because of these episodes. Mr Harris reported that he knew when an episode was coming and could sit until it would pass. He was prescribed carbamazepine to be taken each morning and night.[6]

22. Mr Harris also frequently suffered tooth aches and associated pain from his dentures.

23. When Mr Harris entered his last period of imprisonment, he was subject to two Notifications of Concern relating to potential self-harm. Because of this Mr Harris was permanently flagged and reviewed monthly. He was initially assessed as being at elevated risk after he disclosed multiple psychosocial stressors including concerns for the welfare of his partner, legal matters, placement concerns and decreased likelihood of family visits.[7]

24. During an assessment on 24 July 2014, while on remand for murder, Mr Harris for the first time disclosed that he had attempted suicide in 2012 by overdosing with heroin and his partner had to revive him.

25. The disclosure of the attempted suicide in 2012 was an additional reason that Mr Harris was assessed as having an elevated baseline risk. There were no other reports of self-harm or suicidal ideation prior to this report in 2014.

Corrective Services History

26. On 4 July 2018, Mr Harris was transferred from Wolston Correctional Centre to Capricornia Correctional Centre in Rockhampton. This transfer was involuntary and due to an association issue. When Mr Harris first arrived, he requested that he be managed on a safety order with conditions including segregation due to his concerns about sharing a cell and his epilepsy.[8] He spent much of his time at the Capricornia Correctional Centre in the detention unit.

27. Four months later, Mr Harris was transferred to TCC where he stayed until his death. He was moved there after he requested the transfer to be closer to Ms Appleton, who was located at the Townsville Women's Correctional Centre. QCS submitted that as Mr Harris was a protection prisoner, he had to be placed in the Harold Gregg Units as it was the only protection unit at the TCC.

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[5] After being assaulted in 2000.
[6] QPS report, Exhibit A6, page 9
[7] The QCS policy on At-Risk management recognises that "a prisoner with chronic or an elevated baseline risk is likely to present with ongoing risk factors that contribute to higher rates of suicide or self-harm in comparison to the general prison population, however, are not currently acutely at risk and do not require crisis interventions such as observations".
[8] Mr Harris was housed alone in cells at each facility. He had stated "I am in for 2 murders and if I get a cell mate 2 people will go in and 1 person will come out".

28. When Mr Harris arrived at TCC on 7 November 2018, Psychologist Leah McAllister assessed him before he was accommodated in the Harold Gregg Units because it did not contain 'safer design' cells. She wrote that he:

> *Denied any current self-harm or suicide ideation, plan or intent. He reported that he would not notify officers if this were to change as he did not feel that it would change. ... Prisoner Harris' placement in Harold Gregg is deemed appropriate based on nil history of hanging behaviours*.

Events leading up to the death

29. Mr Harris was the sole occupant of cell 10 in the Harold Gregg Unit 3. On 3 July 2019, CCO Forman conducted a headcount of prisoners at approximately 8:40 pm.[9] He told the inquest there were 117 prisoners in the unit on that night.

30. CCO Forman noted that Mr Harris appeared in good health and was not displaying any unusual behaviours. He stated that there were no observable indicators to suggest that he was under stress or intended to self-harm. He told the inquest that if he was concerned, he would have raised a Notice Of Concern and stayed with Mr Harris until he could be moved to the Safety Unit for supervision.

31. CCO Forman described Mr Harris as an intense and highly strung prisoner who could be verbally abusive but would invariably apologise afterwards. He said he was a "needy" prisoner who knew how to access services within the prison. He thought that he may have been a union representative if not in prison because of his willingness to advocate on behalf of other prisoners. He was a leader among the prison population.

32. The next morning at approximately 4:50am CCO Forman conducted a headcount and when he checked Mr Harris' cell, he saw Mr Harris' bare back blocking the viewing window. He was very still and did not appear to be moving. CCO Forman tapped on the glass with the torch and could see a strip of sheet tied around the bars above the door. When he shone the torch up through a small gap in the viewing window, he could see the same sheet tied tightly around Mr Harris' neck. He called a code blue at 4:52am.

33. Three other CCOs arrived and CCO Forman unlocked the door. CCO Trevor supported Mr Harris while CCO Heames cut the sheet from Mr Harris' neck by using his cut down knife.

34. Two officers placed Mr Harris' body on the cell floor. He was cold and stiff, and the officers noted the pronounced dark purple markings around his neck. There was no pulse and CCO Forman commenced chest compressions. During compressions CCO Forman heard a gurgling sound and saw a strong-smelling fluid discharge from Mr Harris' mouth and ears. CCO Trevor checked Mr Harris for a pulse and commenced CPR.

35. At approximately 5:00am a nurse arrived and attached the defibrillator. CPR efforts continued until the arrival of the Queensland Ambulance Service (QAS) at 5:24am. Mr Harris was pronounced dead shortly after the QAS arrival.

[9] This varies in different exhibits between 8:40pm and 8:50 pm.

36. CCO Forman said that after other prisoners had been alerted to Mr Harris' death, there was a degree of commotion in the unit with some prisoners blaming a particular prisoner.

37. CCO Forman also said that his training in relation to suicide prevention and other relevant policies was up to date at the time of the death.

QAS Attendance

38. No statements were taken from the QAS officers. There was considerable discussion in the inquest brief regarding policies and procedures of the prison in relation to who has the authority to declare someone life extinct. There appeared to be confusion between the nurses and CCOs in this regard.

39. Paramedic, Bianca Williams, noted Mr Harris was life extinct on 4 July 2019 at 6:13 am.[10]

Autopsy results[11]

40. On 8 July 2019, Forensic Pathologist, Dr Andrew Kedziora conducted an autopsy consisting of an external and full internal examination of the body.

41. The external examination showed an injury on the neck which was a circumferential abrasion and impression in the skin around the neck. This was consistent with having been made by the bedsheet that was presented to the doctor at autopsy. There was a fracture of the left greater horn of the hyoid bone.

42. There were no suspicious external or internal injuries and no obvious sign of significant natural disease.

43. The toxicology results showed the presence of codeine, antiepileptic Carbamazepine, an anti-inflammatory and paracetamol.

44. Dr Kedziora concluded that the cause of death was:

    1(a) Hanging

Investigation findings

CSIU investigation[12]

Harold Gregg Protection Block

45. Mr Harris was placed in the protection block, Harold Gregg Units. The unit is small with a common area that leads to a long corridor with twelve cells. There are two floors with identical layouts. The unit has electronically operated doors which cannot be opened by prisoners inside their cells. The cell doors are

[10] Exhibit A2.
[11] Exhibit A5.
[12] Report dated 14 February 2020.

remotely operated by master control after lockdown and opened by a central control system located inside the unit when it is staffed.

46. Mr Harris was housed in cell 10. Cell 10 had a single door that had a small glass viewing window. The cell has a row of bars above the access door.[13]

47. Mr Harris was the only occupant. The cell has an adjoining shower and toilet which can only be accessed from cell 10. Next to the bunk was a bookshelf with Mr Harris' personal items. There was a bunk bed with a mattress on the lower bunk only. The bed was made. On the top bunk was a small ligature and sheets. Police saw a small blade under the sheet. On the pillow on the bed was a single page letter in front of the pillow at the far end of the room. Police also observed two envelopes containing letters at the foot end of the bed. The letters were addressed to Mr Harris' partner and mother.[14]

Indications of suicidal ideation

48. A door knock was conducted by CSIU officers of all cells in the unit. Most of the prisoners either refused to speak to police or said they did not know Mr Harris. The prisoners who did talk to Police stated that Mr Harris was the 'peacemaker' of the unit,[15] was a fit and quiet person and would either be working out or drawing.[16] Mr Harris was a talented artist.

49. There was a lockdown event the night before Mr Harris' death because prisoners were on the roof and the unit was loud. Prisoners said that Mr Harris was "up and down" and if he did not get his letters from Ms Appleton '*he would go off*' as he *'lived for his letters.'*

50. One prisoner told Police that Mr Harris was upset Ms Appleton had started the Subutex program as he was against drug use. He was also concerned about his mother's health. The same prisoner said there was no indication he was going to suicide, and another said while he had been down lately, he was shocked when it happened.

Supervision of Mr Harris leading up to his death

51. Mr Harris was permanently flagged as he had experienced two Notice of Concern episodes in 2014. He was to be reviewed monthly and the Protection Unit was deemed to be a suitable unit for him to be housed. When he was inducted in the TCC he stated he had previous thoughts of suicide but no current thoughts of self-harm or suicide. Mr Harris told officers at that time that his main support was Ms Appleton and that he would 'never leave her posted' as they were both serving life sentences.[17]

52. The CSIU Report noted that as Mr Harris was in a secure unit he was supervised more closely and had appeared to be mostly in good mental health. Prison staff did not have concerns that he would self-harm or take his own life.

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[13] Exhibit A6, page 6.
[14] Exhibits D2 and D3.
[15] Exhibit D4.
[16] Exhibit D4.
[17] Exhibit A6, page 10.

53. The CSIU investigation concluded that the death was not preventable as compliance with policy was adhered to. There were no indications that he had been contemplating suicide. There appeared to be no suspicious circumstances. There was no evidence of any assistance or intervention from any other person.

Office of the Chief Inspector investigation[18]

54. A considerable part of the Office of the Chief Inspector report was dedicated to policies and procedures in relation to steps to be taken after the discovery of a deceased prisoner. Three of the five recommendations were related to that portion of the report. The other two were relevant for the inquest:

    1) *That the Chief Superintendent of Townsville Correctional Centre ensure that the process of gathering and analysing intelligence information includes identification and reporting of all known risks, including risks of suicide and self-harm, in accordance with COPD – Risk Management; and*

    5) *The Deputy-Commissioner, Custodial Operations, ensure suitable governance and assurance are in place regarding the assessment, management of prisoners and recording of decision-making regarding cell placement of prisoners to minimise the risk of suicide by hanging.*

55. The investigation made several findings before making those recommendations. These included:

    a. That Mr Harris' behaviour in the weeks before his death was consistent with known at-risk indicators, but that staff considered this was normal for him and did not flag it as significant.

    b. The Harold Gregg Units in their current configuration are not suitable for housing prisoners showing at risk behaviours and elevated base line risks.

    c. Mr Harris was having problems communicating with his partner and that this was likely to have put him under increased stress. It was noted that they met the criteria for inter-facility contact and that they offered each other considerable support and should have been allowed to have more frequent phone contact.

56. The OCI report noted that on 19 June 2019, Correctional Supervisor Geoffrey Pollard audited Mr Harris' case notes and noted that Mr Harris could be accommodated in the Harold Gregg Protection Block as nothing in his case notes during the audit period indicated that he was a prisoner at risk of self-harm. Mr Pollard noted that he had a SHEH (Self-Harm History) flag and was therefore considered to be at an elevated baseline risk for self-harm.

57. Mr Pollard was asked if incidents earlier in June 2019 affected his assessment. These incidents were reports of Mr Harris being upset, in the context of discussions of transfers and making threats towards other prisoners. After these incidents Mr Harris calmed down and would apologise. He was also approached and specifically questioned about self-harm and denied such thoughts.

[18] Exhibit F1 - Report dated August 2020.

58. Mr Pollard stated that he:

> *'usually looked for drastic behaviour change, unusual events and threats from other prisoners. Mr Harris kept to a routine and disliked having to share the exercise yard with other prisoners, who often frustrated him. 'Yelling at the rest of the unit would be normal for him.' He sought staff help if he had issues and rarely acted alone. His death was a shock.'*[19]

59. Mr Shaddock told the inquest that prisoners with an elevated baseline risk can be placed in the old stock cells where there are mitigating factors, including no current at risk behaviours.

60. The OCI report noted that some of Mr Harris' behaviour in the weeks leading up to his death was consistent with indicators detailed in the COPD Appendix AR1. His 'varied and intermittent behaviour' did not raise staff concern at the time. It listed the following indicators:

    a. A sense of loss of control over his environment, and intense anger

    b. Gradual social withdrawal and isolation from others

    c. Mood swings, tension, agitation and aggressiveness

    d. Reluctivity and withdrawing from social relationships with other prisoners

    e. Maladaptive coping strategies

    f. Concern of his sentence length, security classification and change of placement.

61. The OCI report analysed the two letters found in Mr Harris' cell. The letter to his mother stated the had been contemplating suicide for months. It outlined his complaints about life in prison. The letter to Ms Appleton appears to have been started in the morning of 3 July 2019. He wrote of looking forward to getting her letters and their next call. However, in the latter part of the letter Mr Harris changed the tone, discussing how he thought the 'leader of a gang' had turned on him, that he had been thinking of suicide every day for months but that he hated the thought of leaving her behind. He stated

    '*I just can't do this anymore babe, an eternity behind bars, never to be released, and living like this is more than I can handle.*'

62. The OCI report noted that while letters between Mr Harris and Ms Appleton were monitored by intelligence officers, they were not reviewed for the purpose of assessing risk of self-harm. In addition, telephone calls between the couple were not monitored.

[19] Exhibit F1, page 13, paragraph 47.

63. Ultimately, the OCI report concluded:

> *'He was not coping well and under stress, but his behaviour, being quick to anger and social withdrawal, was in line with his longer-term behaviour and was not seen to be out of character. Staff could not have known then that he was at risk of harming himself.*[20]

64. QCS advised that implementation of OCI recommendation 1 was approved and closed by the QCS Operational Oversight Committee on 16 June 2021.[21] Implementation was achieved through the TCC annual Intelligence Management Plan and Information Collection Plan. These require the identification and reporting of all known risks as per the COPD. Intelligence analysts have also met with the senior psychologist for further training in relation to self-harm/suicide risk indicators. The mentoring process for new intelligence analysts includes components on suicide and self-harm risk identification and reporting.

65. QCS also advised that recommendation 5 "may form part of a broader state-wide reform for Queensland Corrective Services to ensure the wellbeing and safety of all prisoners within our custody". These recommendations are presently being reviewed by the Operational Policy and Practice Group within the Policy and Legal Command, who are considering the implementation of the recommendations.

Family concerns

66. A statement from Mr Harris' mother was taken by police on 26 August 2019. She told police he had never spoken to her about having suicidal thoughts but that he had frequently complained about TCC. He complained about the treatment of prisoners in the corrections system, particularly the food and lack of air conditioning. Her belief was that Mr Harris would never have planned to take his own life but that he would have done so as a "spur of the moment decision".

67. Linda Appleton was interviewed by police[22] and by the investigators from the Office of the Chief Inspector.[23] During both interviews Ms Appleton was unable to add anything of note to what his mother had told police. There were the same complaints of prison conditions and delay in mail. Ms Appleton said that Mr Harris had told her in the past that the only way he would take his own life was if they did it together.

68. However, she stated that a couple of months in the lead up to his death he wrote concerning statements in his letters such as wishing he could go to sleep and never wake, up but that he would then brush it off. Ms Appleton believed he did not reveal too much in his letters because they were both aware that their mail was subject to review by intelligence officers. Ms Appleton was surprised TCC did not have Mr Harris on observations.

[20] Exhibit F1, Page 15, paragraph 60.
[21] Exhibit C27
[22] Exhibit B1
[23] Exhibit F69 (audio) and F69.1 (transcript)

Conclusions

69. I have considered the case notes and documents in relation to Mr Harris' general behaviour and demeanour in the lead up to his death. I agree with the conclusions reached in the OCI report and by DSC Schenk that staff would not have been readily able to discern suicide risk indictors in the weeks leading up to his death in the context of his usual presentation, which included him being quick to anger and socially withdraw. I also accept there were no suspicious circumstances.

70. Mr Harris was assessed by a prison psychologist when he was transferred to the TCC at his own request. He denied having any thoughts, plans, or intent to self-harm. As he had disclosed a previous attempt at suicide from 2012 while he was living in the community, he was required to be regarded as having an elevated baseline risk. Two notices of concern were also raised in 2014, but those were not related to suicidal ideation.

71. As a protection prisoner there was no accommodation for Mr Harris at the TCC other than the Harold Gregg Protection Unit, which consists of old stock cells with exposed bars. Although he had been assessed as having an elevated baseline risk, he had been in custody between 1991 and 2013, and then from 2016 until the date of his death without any recorded incidents of attempted self-harm in custody. I accept in those circumstances that there were sufficient mitigating factors to justify his placement in the Harold Gregg Unit with an elevated baseline risk.

72. The last phone call between Mr Harris and Ms Appleton reflected that he was clearly frustrated with several matters including delays in the delivery of their letters, the misuse of the Subutex programs by prisoners, the fact that Ms Appleton was on that program and recent lockdowns. However, he spoke calmly and coherently. He also spoke about the future.

73. The two letters left by Mr Harris in his cell indicate that he had been considering ending his own life for months before his death.

Findings required by s. 45

Identity of the deceased – John Edward Harris

How he died – On 3 April 2014, Mr Harris was remanded in custody on charges that included murder. In October 2016, he was sentenced to life imprisonment with parole eligibility in 2041. He died the day after the fifth anniversary of his remand into custody. He had no history of suicidal ideation in prison. He intentionally took his own life after fashioning a ligature from a sheet 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 – Townsville Correctional Centre, Stuart, Queensland

Date of death– 4 July 2019

Cause of death – Hanging

Comments and recommendations

74. Section 46 of the *Coroners Act 2003* 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.

75. 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 comment about those matters.

76. The OCI report noted that there were seven deaths by hanging at Queensland Corrective Services facilities between November 2015 and March 2019, three of which involved ventilation bars above cells. One of those, the death of Dylon Ahquee, also occurred in the Harold Gregg Unit in December 2015.

77. Mr Shaddock's statement[24] indicated that the elimination of hanging points in prison cells had been ongoing since recommendations were made in 2011 and 2012 by State Coroner Barnes in the inquests into the deaths of Christopher Bell, Robert Mitchell and Adam Cartledge, who each died by hanging at the Arthur Gorrie Correctional Centre.

78. Mr Shaddock said that in 2000, 69% of the secure cells in correctional centres used a safer cell design. As at 30 June 2021, 92.9% of all secure cells in correctional centres have been upgraded to safer cells. There remain 340 "old stock" cells within Queensland that are waiting to be modified, with 72 cells in the Harold Gregg Unit at TCC and 268 cells at Arthur Gorrie Correctional Centre. The cost of the provision of safer cells in the Harold Gregg Units was estimated at $45 million.

79. Mr Shaddock said a business case has been developed for the consideration of the Queensland Government. The business case encompasses several components including:

    - Capacity management;
    - Health services provision;
    - Suicide and self-harm reduction (incorporating safer cells); and
    - Security management.

80. I commented on the issue of hanging points within Queensland Correctional Centres in my findings in relation to the death of SVE, where I recommended 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 recommendations on that issue at this time.

[24] Exhibit B7

81. I extend my condolences to Mr Harris' family and friends. I close the inquest.

Terry Ryan
State Coroner
Brisbane