OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Christopher Steven BELL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/946
DELIVERED ON:	26 May 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 April 2011; 23-24 May 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, hanging; adequacy of psychiatric treatment; history of suicide attempts; hanging points

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
GEO Group Australia Pty Ltd	Mr Sandy Horneman-Wren SC
Queensland Health Prison Mental Health Service:	Mr Kevin Parrott
Department of Community Safety:	Ms Kay Philipson
Prisoners' Legal Service:	Ms Kylie Hillard

Table of Contents

The *Coroners Act 2003* ('the Act') provides in s47 that when an inquest is held into a death in custody a copy of the findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system including the Attorney-General and the Minister for Police, Corrective Services and Emergency Services. These are my findings in relation to the death of Christopher Steven Bell. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

Christopher Bell had suffered from the debilitating symptoms of his schizophrenia for several years by the time he found himself remanded in custody at the Arthur Gorrie Correctional Centre (AGCC) on 29 October 2009. Although he had attempted suicide years earlier and was apparently suffering from psychotic episodes when admitted, he was not considered to be at elevated risk of suicide or self harm at any time during his almost six months at AGCC. Despite an apparent steady improvement in his psychiatric state during his incarceration, on the morning of 18 March 2010 Mr Bell was found hanging in his cell.

This is a death in custody and the Act therefore requires an inquest be held by the state coroner or deputy state coroner.

This report:-

- Contains my findings as to the identity of the deceased person and when, where, and how he died and the medical cause of his death;
- Considers whether any changes should be made to policies and procedures governing the provision of mental health care to prisoners; the sharing of information between agencies; or the way in which prisoner accommodation is allocated;
- Records, yet again, the continued failure to fulfil a commitment made by the Queensland government in 1991 to remove hanging points from all prison cells;
- Assesses the adequacy of the investigation into the death.

The investigation

Two officers from the QPS Corrective Services Investigation Unit (CSIU) were already at AGCC on the morning of 18 March 2010 investigating other matters. They attended unit B2 where Mr Bell was accommodated shortly after his death. They were, therefore, in a position to observe and then direct security at, what was by then, the crime scene. A log of events was appropriately commenced by a corrective service officer (CSO). All inmates remained locked in their cells for the duration of the crime scene investigation.

Other CSIU officers attended the scene and Detective Senior Constable Raelene Speers was assigned the role of lead investigator. She later provided a comprehensive report of her investigation to the Office of the State Coroner.

On arrival, the CSIU officers directed scenes of crime officers in the collection of exhibits. Photographs were taken of the scene and, later, of the autopsy examination. Samples of fingerprints as well as a number of swabs were taken from various parts of the cell at the direction of Detective Speers. She later arranged for the seizure of all records relating to Mr Bell from AGCC.

Detective Speers obtained statements from all relevant AGCC and Prison Mental Health Service (PMHS) staff. All prisoners in Unit B2 were interviewed. Records pertaining to Mr Bell's criminal and psychiatric history as well as his earlier extradition to Queensland were obtained.

In addition to the QPS investigation, a further investigation was ordered under the relevant provisions of the *Corrective Services Act 2006* by the Chief Inspector, Queensland Corrective Services (QCS). That investigation was conducted by a QCS inspector and an independent consultant. Encouragingly, it has been my experience in previous inquests that such investigations are rigorous and independent. The report in this case confirms that impression. I have been assisted by the findings and recommendations of the report. This inquest has attempted to build on that process by examining the steps already taken in response to this report.

I am satisfied this matter has been thoroughly and professionally investigated and that all relevant sources of information have been accessed and analysed. I commend Detective Speers for her efforts.

The inquest

The inquest was opened with a pre-inquest conference on 13 April 2011. Mr Johns was appointed counsel assisting and leave to appear was granted to GEO Group Australia Pty Ltd (the operators of AGCC), Queensland Health and the Department of Community Safety. Pursuant to s36(2), the Prisoners Legal Service was given limited leave to pursue issues of public interest. The inquest was convened in Brisbane on 23 May 2011 and evidence was heard over two days.

The evidence

I turn now to the evidence. I have not summarised all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made

Social history

Christopher Bell was born in Upper Ferntree Gully on 31 January 1983 to his parents Graham and Heather. He had an ostensibly normal childhood both there and, from the age of 11, in Tamworth. Leaving school in year 11 he began working as a roofer but began to suffer the first symptoms of his mental illness at around 18 years of age.

Sadly, Mr Bell's mental illness, later diagnosed as schizophrenia led him to an itinerant lifestyle, and ultimately, only intermittent contact with family

members. The very nature of the psychosis suffered by Mr Bell; namely that he believed, among other things, that people nearby could read his thoughts made it difficult for him to live in share or communal accommodation and receive the services that are available in such facilities.

The perspective of Mr Bell's family was that he would have periods of settling into place while taking medication and then suddenly disappear. Mr Bell's father Graham reported that in these circumstances he would occasionally get a phone call from a stranger some time later letting him know where Christopher was living. It is clear from their involvement in these proceedings and the other evidence tendered that Mr Bell's parents provided as much care and support to their son over the years as was possible in the circumstances. I note Mr Bell was quick to refer his treating psychiatrist at AGCC, Dr Jillian Spencer, with his father's details so she could gain a better understanding of his history. There is no doubt Mr Bell's death has greatly distressed his family and that he was very much loved and is greatly missed. I offer them my condolences.

Criminal and mental health history

It appears Mr Bell began to suffer the first manifestations of his psychiatric illness in his late teens. This was in the form of auditory hallucinations – hearing voices that over time caused him to believe people nearby could hear or decipher his thoughts. He was ultimately diagnosed as suffering from schizophrenia. Mr Bell told Dr Spencer that in the early stages these voices convinced him his life was in danger and would tell him to 'shut up'. This led early on to a failed attempt at suicide involving him jumping from a bridge in Katherine. This incident is described consistently by Mr Bell throughout various assessments made available to me in the evidence. In some assessments he appears to have stated that this was his only attempt at suicide, but in others he also reports a 2005 incident where he required hospital treatment as a result of overdosing on Risperidone while living in Rockhampton.

Mr Bell was first placed on medication for his condition in 2004 and in the lead up to his incarceration in October 2009 he had been prescribed the anti-psychotic medication Risperidone Consta at a dosage of 50mg per fortnight.

Mr Bell began using illicit drugs from about the age of 17. Starting with cannabis he later moved to occasional use of amphetamines. This was supplemented with periodic paint sniffing and an ongoing heavy alcohol intake. Likely associated with his psychiatric history and drug use was a criminal history involving property offences, assault and armed robbery, the latter offence resulting in a period of imprisonment in Victoria lasting around 4 months in 2007.

On 3 May 2005 an arrest warrant was issued for Mr Bell after he failed to appear in the Brisbane Magistrates Court in relation to several charges of property offences alleged to have occurred in June 2004.

An arrest warrant was also later issued in relation to an allegation of rape said to have occurred at Surfers Paradise on 7 March 2004. While that charge had not by the time of Mr Bell's death been adjudicated by a court, there was a strong prosecution case and he made admissions to Dr Spencer. He certainly appeared resigned to receiving a period of imprisonment as a result, indicating at one point that he expected to serve 10 years. There is no evidence as to whether there was an intention to explore his fitness to plead or his state of mind at the time of the alleged offence. Even if it was the case that this matter was to be diverted to the Mental Health Court, there is no suggestion this would have led to him being released from custody before March 2010.

Watch house assessments

On 27 October 2009 Mr Bell was extradited to Queensland where arrest warrants on outstanding property offences and a charge of rape were executed. He was remanded in custody after appearing in the Southport Magistrates Court on 28 October 2009 and was transported to AGCC the following day.

While in the watch house Mr Bell was assessed by Cassie O'Connor, a psychologist with the Queensland Health Forensic Mental Health Service at Southport. Ms O'Connor recorded Mr Bell's long term history of schizophrenia and his view that he had responded little to medication. She recorded the symptoms of his psychosis and noted he found the intrusive thoughts quite distressing at times.

Ms O'Connor recorded that Mr Bell had attempted suicide on a number of occasions including the bridge incident in Katherine and other incidents of overdosing on medication. She noted he had not made any attempts at suicide for several years and denied any current thoughts of suicide or self harm. She did, though, make the following statement:

> "*While currently Mr Bell appears reasonably settled he is concerned about longer term incarceration and being confined with others for lengthy periods. He denies current self harm, suicidal thoughts or thoughts of harm to others however this could change in the context of the environment."*

In a questionnaire apparently filled in by Southport watch house staff – the QPS Person Report, Mr Bell was asked "*Have you had thoughts of suicide or self harm now or in the last 3 months".* The answer recorded is "*Yes*".

Transfer to AGCC

On arrival at AGCC on 29 October 2009 Mr Bell was interviewed by Christophe Closson, an AGCC psychologist charged with conducting an Initial Risk and Needs Assessment (IRNA). New to the role, Mr Bell was one of the first prisoners he had been allowed to assess unsupervised. Mr Closson told the inquest he could not recall whether he had access to the QPS Person Report from Southport watch house but expects this would have been the case, and he would have read it. He did not have the assessment report of Ms

O'Connor because she was a Queensland Health employee and the data she gathered was considered to be confidential to medical practitioners.

This highlights the separation between Mr Closson's role as a psychologist employed by the operators of AGCC and that of mental health staff working for PMHS. The latter are employed by Queensland Health and confidentiality requirements mean that only limited information about their patients can be passed on to those working for the correctional facility. As will be seen, information sharing protocols are in place in order to reconcile this separation with the need for prison staff to be fully informed on matters of safety.

Mr Closson concluded Mr Bell did not meet the criteria to be classified as a prisoner with an 'elevated base-line risk' (EBR) of suicide or self harm. He based this on, amongst other reasons, Mr Bell's denial of any present suicidal ideation, his demeanour and the age of his previous suicide attempt. Mr Closson appropriately recorded the one previous suicide attempt disclosed to him. The effect of this was that a 'flag' appeared on Mr Bell's record on the Internal Offender Management System (IOMS) – the computer record available to all CSO's. He also properly referred Mr Bell to the PMHS for further assessment and treatment notwithstanding his assessment that Mr Bell did not have an EBR of suicide.

Mr Closson was required to ask Mr Bell as part of the IRNA process whether he had thought about suicide in the past week. He says Mr Bell denied this and also denied suicidal ideation since his suicide attempt many years before. At the inquest Mr Closson agreed he probably should have explored the inconsistency between Mr Bell's answer to him and his answer to the similar questions on the QPS Person Report. This was not done but it had no impact on the way Mr Bell was treated in the correctional centre or the events which followed.

Contact with PMHS

Mr Bell saw Ms Corrine Clifton, a PMHS psychologist on 3 November 2009 for a triage assessment. She noted the history and nature of Mr Bell's condition and his current medication. Ms Clifton recorded the following on the issue of Mr Bell's suicide risk:

> *"Reported he attempted suicide by jumping off a bridge in 2001* 'just after I started being telepathic'. *Reported currently* 'I'd prefer to be dead so I wouldn't have to put up with people reading my thoughts and fear'*. Further stated* 'If I had a gun right now I'd shoot myself'. *Suicide ideation appears to relate to chronic psychotic symptomatology (sic) and not wanting to live with these for the rest of his life. He denied suicide plan in custody".*

This information was not passed onto to either the custodial officers responsible for Mr Bell nor the psychologist working for the prison operators. Ms Clifton denied considering any policy or legislative impediment to passing on this information to the prison psychology service if she had considered it necessary. She clearly had an understanding of the systems and procedures

by which such information could be supplied in circumstances where she considered the prisoner posed a threat to himself or others. In urgent cases this information could be passed directly on to prison psychology staff and the prisoner then reviewed as part of the EBR protocol. She also attended weekly mental health meetings with other PMHS and AGCC staff where she would provide a summary of her patient's circumstances. She was unable to say whether she related the passage from her notes set out above but it appears unlikely. Ms Clifton also told the inquest she had not been trained in, and had little understanding of, the criteria applied by prison staff as part of the EBR system. She had limited understanding of the accommodation options available at AGCC at least in terms of how many cells are considered to be suicide resistant.

I am of the view Ms Clifton made an error of judgement in this regard but I also conclude it had no negative impact on the way Mr Bell was monitored or treated while in AGCC.

She told the inquest it was her belief the suicidal ideation being expressed by Mr Bell was not acute; that it was an ongoing aspect of his chronic condition and in the absence of any current plan or intention to commit suicide she did not consider the information worthy of being specifically drawn to the attention of AGCC staff. It was her understanding, correctly, that this information would be provided to a psychiatrist who would be in a position to make a further expert assessment in any event.

This occurred on 20 November 2009 when Mr Bell was seen by psychiatrist Dr Jillian Spencer. She completed a detailed record of Mr Bell's psychiatric state and history. The following entries made by her give a good understanding of her assessment of Mr Bell in those areas with which the inquest is concerned:

> "***Mental State Examination***
>
> *Adult male, solid build, clean, in prison garb. Bearded. Good eye contact, intense at times, but not hostile. Not agitated.*
> *Speech: fluent, normal rate and volume, mildly monotonous.*
> *Mood: anxious*
> *Affect: decreasing intensity (blunting)*
> *Thought: normal tempo. Complex delusional system. Not suicidal.*
> *Perception: constant auditory hallucinations*
> *Cognition: alert, orientated*
> *Insight: reasonable in some respects – requesting protection status but poor insight into psychotic symptoms.*
> *Judgement: not impaired*
>
> ***Impression:***
> *26 year old man with chronic psychotic illness (schizophrenia)*
> *History of poor compliance, itinerancy, few relationships, unemployed.*
>
> ***Plan:***

Continue consta

- *add Olanzapine 5mg nocte for sedation*
- *fasting bloods*
- *liaise with Father*
- *consider clozapine Rx*
- *advised officers about need for more protection*
- *review in 1/52"*

Dr Spencer elected to continue Mr Bell's current dose of 50mg/fortnight of Risperidone Consta and prescribed him Olanzapine Nocte. The purpose of the latter was to assist Mr Bell with his sleep given that he had reported a worsening of symptoms at night. She had also given consideration at this early stage to possible future treatment with the drug Clozapine which is a 'second-line' antipsychotic medication for those schizophrenic patients not responding to other medications. It is a second line drug because its side effects, while rare, are serious involving a lowering of white blood cells and some cardiac risk.

Records show Dr Spencer made telephone contact with Mr Bell's father and aunt over the following days. Records show her requests with respect to protection for Mr Bell were appropriately addressed by his being placed in Unit B2. Dr Spencer did not consider that an urgent or involuntary transfer to hospital was required for Mr Bell but was concerned enough that she drafted a detailed memo to the Clinical Director of the High Secure Inpatient Service (HSIS), Dr Darren Neillie on 25 November 2009. In that memo she explored the possibility of commencing Mr Bell on Clozapine and queried whether the HSIS might be the best place to commence that process which must be done under strict control and monitoring.

Dr Spencer saw Mr Bell again on 27 November 2009. There was no indication his psychotic symptoms were showing any significant signs of improving.

Consideration of HSIS transfer

The HSIS at The Park has 61 beds although the PMHS Clinical Director, Dr Andrew Aboud told the inquest this will increase to 90 in the course of the next year. The inquest spent some time exploring the different transfer options available to a remand prisoner like Mr Bell. Although transfers to other accredited mental health facilities are possible in theory, such transfer requires the operator of the receiving facility to accept responsibility for the security of the prisoner. Dr Aboud acknowledged that in all likelihood the only facility that was going to be able to cater for a remand prisoner on a charge of rape was the HSIS at The Park.

A weekly meeting is conducted by the HSIS which involved staff from that facility as well as other psychiatrists from across the PMHS. It is used for various purposes including discussion of those prisoners on the waiting list to enter the HSIS as well as a forum for the sharing of ideas on treatment options for prisoners who might be under consideration for future transfer. Mr Bell was added to the list of prisoners for discussion at the meeting of 2 December 2009. He remained on the list for the following two weekly

meetings before being withdrawn. At the time no minutes of the discussion in relation to individual prisoners was kept although this has now been rectified. The evidence from Drs Aboud, Spencer and Neillie, who were all in attendance at that meeting, is that Dr Spencer was advised to try an increased dose of Mr Bell's existing medication before commencing a trial with Clozapine.

This suggestion was based on the need to confirm that Mr Bell's condition was in fact treatment resistant to his current medication rather than just being exacerbated by illicit drug use, before the more risky alternative of Clozapine was explored. It seems this was readily agreed to by Dr Spencer and she put this into practice by increasing the dose of Risperidone Consta to 62.5mg/fortnight when she next saw Mr Bell on 11 December 2009.

Although no minutes of the HSIS meetings were kept there was a log which noted those prisoners on the waiting list for the HSIS. Dr Neillie told the inquest that in the period while Mr Bell was being discussed at the weekly HSIS meeting he was on the waiting list (and was the 10th in line for a place). When he was removed, the reason cited on the log was to the effect his existing medication was to be increased and that Mr Bell had agreed to this increase. It was not entirely clear why Mr Bell did not remain on the list until he could be assessed to determine whether the increased dose was having any effect. The system at HSIS did allow for prisoners to be readily added again to the waiting list and for discussion at the weekly meetings if necessary. I was also advised that, in any event, the waiting list was based not so much on when the prisoner was added but on the urgency of their clinical needs.

Mr Bell was not seen by a psychiatrist again until 7 January 2010. At this time, and on his only subsequent psychiatric assessment on 5 February 2010, it appeared his condition had improved. On the basis of the contemporaneous notes of Dr Spencer it seems his psychotic symptoms had abated by 5 February 2010. On that date Mr Bell stated he was not hearing voices any more and even volunteered that "*it might be the medication*". As in earlier interviews he denied any thoughts of self harm or suicide. He reported regular visits from his father and stated he was interacting without any conflict with the other prisoners. He did not report any distress and although still relating some unusual ideas and concepts appeared to be more stable than at any earlier time during his stay at AGCC. Dr Spencer says she had decided after the consultation on 7 January 2010 that there was no further need to consider a transfer of Mr Bell to the HSIS for a work up preparatory to a change to Clozapine.

The inquest also heard evidence from CSO Kylie Muscat who had ongoing interaction with Mr Bell in unit B2 at AGCC in the months before his death. Ms Muscat found that Mr Bell kept very much to himself and avoided activities such as going to the gym; preferring to stay in his cell whenever that option was available. She says she raised this with him but was assured by Mr Bell that he just preferred him own company. She was not privy to his psychiatric

history. In the period immediately prior to his death she did not notice any changes to Mr Bell's demeanour or daily routine.

Events of 18 March 2010

Regular welfare checks conducted through the morning of 18 March 2010 up until 9:15am indicated that all prisoners in unit B2 appeared to be in good health. The 9:15am check coincided with floor lockdown in preparation for gym access. Most prisoners left their cells and were accompanied by the CSO's to the gym. Five prisoners, including, as usual, Mr Bell, remained in their cells. In addition to individual cell doors being locked, the unit as a whole was secured.

When the party returned to unit B2 from the gym at 10:55am, CSO Gianna Iacuzzo commenced unlocking of cells. At 10:59am he came to cell 10 where he saw through the window in the door that Mr Bell was hanging from strips of a white sheet that had been secured to the exposed horizontal bars above the cell door. He immediately notified CSO Muscat and called a Code Yellow (officer assistance) and then a Code Blue (medical emergency).

On opening the cell door CSO Iacuzzo noted a chair close to the door and, with the assistance of another CSO, the noose was cut and Mr Bell lowered to the floor. Another CSO then arrived and cut the noose from Mr Bell's neck.

Three nurses and a doctor attended the cell shortly after the Code Blue was called. It was immediately clear Mr Bell was cyanosed and motionless. He had no pulse. CPR was commenced at 11:03am and later a defibrillator attached although it recommended 'no shock', there being no shockable rhythm. At 11:20am, after continued CPR, Dr Mahomed Kathrada examined Mr Bell and declared him deceased. Dr Kathrada noted bruising on the left side of Mr Bell's neck and superficial abrasions on the front of the neck.

The Queensland Ambulance Service had been notified, but were advised while on their way to AGCC they were no longer required.

The upper landing of unit B2 where cell 10 is located was cordoned off until police arrived. CSO Muscat continued a log of events she had commenced during the medical treatment of Mr Bell.

Mr Bell's body was transported to the Queensland Forensic Science facility at Coopers Plains where his father, Graham Bell, later identified the body.

The autopsy results

Dr Nathan Milne, an experienced forensic pathologist, performed an autopsy on the body of Mr Bell on the morning of 19 March 2010. He found external and internal injuries to the neck he considered greater than usually seen in deaths arising from hanging by a sheet. Dr Milne stated this could be explained by the greater force associated with the deceased (at 113kg) having stepped from a chair. He found no other internal or external injuries on other parts of the body and no significant pre-existing disease.

Toxicology testing of blood samples taken at autopsy showed a therapeutic concentration of Risperidone as would be expected. No illicit or unprescribed drug, nor alcohol, was detected.

There was no evidence found at autopsy of foul play or of the involvement of another person in the death of Mr Bell.

Dr Milne issued an autopsy certificate listing the cause of death as:

1(a). Hanging

Expert evidence

The inquest heard evidence from several experts. Mr Rod Elsworth, a Senior Psychologist with QCS was initially engaged by the QCS Office of the Chief Inspector (OCI). Dr Jill Reddan, an independent psychiatrist, was engaged by my office. In addition to these experts who were not involved in Mr Bell's case, the inquest also benefited from the opinions of Drs Neillie and Aboud on matters beyond their direct involvement.

Mr Elsworth was primarily critical of the criteria on which EBR is assessed believing them to be too broad, not evidence based and of little assistance to psychologists performing the IRNA. The need to review and amend the EBR criteria was put forward as a recommendation by the OCI report. I was advised at the inquest that this has resulted in a large scale review of that procedure and more specific, evidence based criteria will be put in place. I am satisfied this is being done adequately, further as it was not so obviously linked to Mr Bell's death I need not address the specific measures being contemplated.

Mr Elsworth also expressed concern that Ms Clifton had not passed on information arising from her triage assessment on 3 November 2009 to AGCC staff. I have dealt with that earlier in these findings.

Dr Reddan took the view that the assessment of Mr Bell by the PMHS were "*good and of more than adequate quality*". She took the view that the improvement shown by Mr Bell was more likely associated with his withdrawal from illicit drugs rather than the increased dose of Risperidone Consta. Insofar as there was any criticism made, it was that ideally Mr Bell would have been seen by a psychiatrist earlier than he was, although she considered this had no bearing on the outcome.

Dr Reddan also focussed on the inherent difficulty and unreliability of predicting which individual prisoners among a cohort of high risk prisoners will actually take their own lives and when. She stated in her report:

> "*The difficulty always with risk assessments are the uncertainties inherent in predictions of the future and also the difficulty in assessing what is essentially a rare event even in the most 'high risk' groups.*

Dr Reddan made the point that being male in a custodial setting was in itself a significant risk factor (something which applied to all inmates at AGCC of course). This was confirmed by empirical evidence put before the inquest in the form of various studies conducted on populations of hospital patients suffering mental illness who have later committed suicide.[1] Attempts to derive common risk factors from the data available in these studies highlighted the difficulty in crafting a useful risk analysis model. The risk factors have been shown over time to be surprisingly disparate, such that in order to identify a majority of those who go on to commit suicide very large numbers of 'false positives' are generated. This tends to render those risk models that might catch even a small majority of ultimate suicides as entirely impractical.

A topical example of this could be seen in the evidence of the AGCC General Manager Mr Howden who suggested on one application of the EBR guidelines, just about all prisoners at AGCC would be considered 'at risk'.

The difficulty in putting in place a system of risk analysis does not mean QCS and AGCC should not continue to strive to improve the EBR and IRNA systems that currently exist. However, it highlights the need for a much more reliable solution that is proven to work. As Dr Reddan says in her report, and I have pointed to in many previous findings:

> "*It has been known for some time that a public health approach of reducing access to means of suicide does reduce the suicide rate significantly".*

This approach contradicts the view that a person intent on committing suicide "will find a way" and that there is therefore no point in seeking to prevent such deaths. I address the practical ramifications of this later in these findings.

Conclusions

The investigation found no evidence of the involvement of a second person in the death of Mr Bell. I am convinced he hung himself by tearing and rolling a strip of bed sheet which was then secured to an exposed bar above his cell door. It is likely he used a plastic chair to assist in securing the noose before the hanging.

First aid was prompt and appropriate but by the time he was discovered Mr Bell was beyond being resuscitated.

I also find there was no indication that could reasonably have been observed by those responsible for Mr Bell's care in custody that should have prompted intervention that could have prevented the death.

I am satisfied the initial assessment of Mr Bell's custodial needs was adequate as was his initial psychological assessment. Thereafter he received competent psychiatric care.

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[1] Ref to studies

There is no evidence to link the adequacy of resources at The Park to Mr Bell's death. Although soon after he arrived at the AGCC he was placed on the waiting list for admission to the HSIS, I am satisfied there were good clinical reasons to delay any such admission until the results of increasing his then current medication were assessed. This was done and there was clearly sufficient improvement in his condition that by 7 January 2010 that transfer to HSIS was no longer indicated.

It is impossible to assess whether more intensive counselling or psychotherapy may have averted the death and in any event there was no indication such resource intensive responses were warranted in Mr Bell's case.

I conclude none of the individuals involved in providing Mr Bell's custodial care or mental health services bear any responsibility for his death and no oversight or failing by any of those providers contributed to the death.

Findings required by s45

I am required to find, as far as is possible, who the deceased person was and when, where and how he came by his death and the medical cause of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The dead man was Christopher Steven Bell.

Place of death – He died while in custody at Arthur Gorrie Correctional Centre at Wacol in Queensland.

How he died - Mr Bell took his own life while in a locked cell alone and suffering from entrenched mental illness that was apparently being adequately treated.

Date of death – He died on 18 March 2010.

Cause of death – He died as a result of hanging.

Comments and recommendations

Section 46 provides that a Coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. That requires the coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

I have determined in this case the way in which Mr Bell's psychotic symptoms appeared to subside in the months leading to his death meant no one could be expected to have foreseen his death when it in fact occurred. I am also

satisfied that most of the issues and recommendations arising from investigations into Mr Bell's death have been or are being addressed.

The report commissioned by the Office of the Chief Inspector (QCS) made recommendations covering the following areas:-

- The QCS and AGCC At-Risk Management Procedures should be amended to ensure watch house records/assessments are reviewed as a matter of course during an IRNA to avoid significant information being overlooked; and there should be included in the IRNA proforma an additional section on watchhouse records, in order to provide an overview of what information was supplied and to confirm the records had been reviewed.

- Current and proposed policies, procedures and agreements should be reviewed to ensure they sufficiently facilitate the sharing of information between the PMHS, QCS and/or the private prison providers

- The EBR procedures should be reviewed

- QCS should issue a direction to all centres, including AGCC, that when allocating prisoners to secure accommodation, prisoners who have a self-harm flag must be placed in modern suicide resistant cells unless other reasonable factors warrant against it; and where such prisoners are not allocated to a modern cell, the reason for the individual decision must be recorded.

I find these recommendations to be well thought out and reasonably comprehensive in addressing the issues arising from Mr Bell's death. As part of the inquest process I made directions that the relevant parties report on the extent to which these recommendations have been implemented. I am now satisfied the recommendations have been implemented or will be finalised shortly. There is therefore no need for me to make further comment about those issues.

There are two remaining issues which may warrant preventative recommendations. They are:-

- The elimination of hanging points from all cells; and
- Community based bail diversion programs for defendants suffering mental illness.

Suicide resistant cells

This inquest has highlighted the inherent difficulty in trying to prevent prisoners taking their life by identifying those most likely to do so and providing them with special treatment including housing in suicide resistant cells. It seems generally accepted even the best risk analysis tools are of limited value. This conclusion buttresses the recommendation of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) that hanging points be eliminated from watch houses and prison cells. The then State

Government accepted that recommendation and committed to implementing it. To the credit of all governments since that has been achieved in relation to police watch houses. However, Mr Bell's death and other deaths can be attributed in part to the failure of successive governments to fulfil that commitment by eliminating hanging points from correctional centre cells.

I acknowledge the evidence tendered in this and other inquests of the very substantial cost associated with implementing the RCIADIC recommendation. I also acknowledge the prioritising of the demands on public finances is properly a matter for government. However, coroners are obliged to draw attention to the negative consequences of those decisions if they result in preventable deaths.

This inquest was told that at the AGCC currently, 20 years after the RCIADIC, 43% of all cells still have exposed hanging points. As I understand their positions, the centre operators and the QCS acknowledge this creates an unmanageable risk – they can't accurately predict which of the numerous at risk prisoners might actually suicide and they can't house all at risk prisoners in suicide resistant cells because there are too many such prisoners and too few such cells.

During the inquest I was advised that further funding will soon be available to continue the process of building new suicide resistant cells and retro-fitting screens over bars in old cells. That of course is to be welcomed and those responsible for the relevant decisions deserve credit for them. However, as these improvements have been promised for 20 years and have still not been delivered those decision makers and their predecessors must also share some responsibility for any deaths that occur between now and when that work is completed.

There is little more I can say to draw attention to the continuing risk.

Bail diversion programs

The PLS submitted that experience here and overseas has shown bail diversion programs whereby those suffering from mental illness are required to live in community placements in which they can better access more intensive mental health services are cost effective and contribute to a reduction in recidivism.

I am easily persuaded that is the case.

The PLS, if I understand its submission correctly, concedes that a prisoner in Mr Bell's situation is unlikely to be offered a place in such a program having regard to the seriousness of the charges he was facing and his poor bail history. Nonetheless, they quite reasonably argue were such programs in place the movement of defendants charged with less serious offences out of correctional centres and into community placements would free up suicide resistant cells for the use of the remaining prison population. I readily accept the logic of those propositions.

However, I do not have anything approaching a sufficient evidence base to justify recommending the introduction of such programs, as sensible as they might sound. Such a significant shift in criminal justice policy would require research and review far beyond the scope of these proceedings. I therefore decline to make any comment in relation to the submission.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
26 May 2011