QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Herbert John MITCHELL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR2011/1318
DELIVERED ON:	14 December 2012
DELIVERED AT:	Townsville
HEARING DATE(s):	23 October 2012, 12-13 December 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody; assessment and care of intoxicated prisoners; diversion of intoxicated persons

REPRESENTATION:

Counsel Assisting:	Mr John Aberdeen
Family of Mr Mitchell:	Ms Paula Morreau (instructed by Boe Williams Lawyers)
Queensland Police Commissioner:	Inspector Wayne Kelly (QPS Solicitors Office)
Queensland Ambulance Service:	Ms Melinda Zerner (instructed by Department of Community Safety)
Senior Constable Craig, Constbale Higgins, Constable Waters & watch house officer Thompson:	Mr Martin Burns SC (instructed by Gilshenan & Luton Legal Practice)

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The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written 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. These are my findings in relation to the death of Herbert John Mitchell. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Mr Herbert Mitchell was arrested by police at Castletown Shopping Centre in Townsville, just after 11:00am on the morning of 17 April 2011, for the offence of being drunk in a public place.

Following the receipt of information from the public, police officers attended Castletown and located Mr Mitchell asleep on a pathway. He was able to be woken, and presented to attending police as being "extremely drunk". Initially, a decision was made to take Mr Mitchell to a diversion centre but when he acted inappropriately there it was decided to take him to the Townsville watch house.

Soon after he was admitted to the watch house his health was reviewed by Queensland Ambulance Service (QAS) officers who advised Mr Mitchell was sufficiently well to be kept in custody at the watch house.

At 3:21pm, he was found by an inspecting officer to be non-responsive, and displaying an absence of vital signs. Attempts to revive him at the watchhouse were unsuccessful.

Mr Mitchell was transferred to the Townsville Hospital by QAS where further attempts were made at resuscitation. He died the following day without having regained consciousness.

These findings:

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

- determine whether the decision to take Mr Mitchell to the Townsville Police Watchhouse, instead of allowing him to remain in the diversion centre complied with relevant policy;

- consider whether the assessment of Mr Mitchell carried out by the QAS was carried out in accordance with QAS policy and best practice;

- determine whether the decision to hold Mr Mitchell in the watchhouse, after QAS assessment, complied with QPS policy;

- determine whether the process of checking the welfare of persons held in the Townsville watchhouse, as applied to Mr Mitchell on the 17 April 2011 (i) was in accordance with the established policies and procedures of the Queensland Police Service, and (ii) was reasonable in all of the circumstances;

- determine whether there is any evidence that any of the injuries which might have contributed to Mr Mitchell's death were caused or inflicted by the act of another person; and

- determine whether there are any grounds to review or amend any policies of the QPS or the QAS with respect to the medical or paramedical review of persons brought to the watchhouse.

The investigation

At 4:35pm on 17 April 2011 Inspector Kerry Johnson received a call from Acting Superintendent Roger Lowe of the Ethical Standards Command (ESC) advising of a probable death in custody. Acting Superintendent Lowe instructed Inspector Johnson to contact Superintendent Campbell, the District Officer of the Townsville Police District to ascertain the details.

Later that afternoon Inspector Johnson briefed other investigators from the ESC to attend Townsville and commence investigations. One of those officers was Acting Inspector Karen Ballantyne who became the lead investigator and later provided a report to the Office of the State Coroner.

Acting Inspector Ballantyne and other officers from the ESC travelled to Townsville, arriving at 9:30pm, and attended the Townsville police station that afternoon. A/Inspector Ballantyne received a briefing and attended the Townsville watch house. After viewing the watch house A/Inspector Ballantyne returned to the police station and she, along with the other ESC investigators, commenced interviewing relevant persons over the following days.

The following day an officer from the Crime and Misconduct Commission (CMC) travelled to Townsville and monitored the investigation.

A/Inspector Ballantyne and the other ESC investigators continued to interview all relevant persons involved with Mr Mitchell prior to his death and collated all relevant watch house records including CCTV taken at the watch house.

An independent expert report was commissioned by those assisting me.

I am satisfied the investigation was thorough and professionally undertaken. I commend Acting Inspector Ballantyne on her endeavours.

The Inquest

A pre-inquest conference was held in Brisbane on 23 October 2012. Mr Aberdeen was appointed as counsel to assist me with the inquest. Leave to appear was granted to Mr Mitchell's family, the Queensland Police Commissioner and several individual officers involved in managing the custody of Mr Mitchell at the Townsville watch house, and the Queensland Ambulance Service.

An inquest was held in Townsville on 12 and 13 December 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. A total of 14 witnesses gave oral evidence and 180 exhibits were tendered.

The evidence

Social and medical history

Mr Mitchell was born on 25 September 1960 at Woorabinda in Queensland. He was the second youngest of nine children - 5 girls and 4 boys - born to Agnes and Harvey Mitchell of Woorabinda.

He grew up initially in Woorabinda, and then moved to Mareeba. From Mareeba, he went to Townsville where he lived with a family - Mr and Mrs Wano - and where he attended both primary and secondary school. Most of his working life involved working on tobacco and banana farms in the Mareeba area, with some time spent in Rockhampton, and back in Woorabinda.

He had one daughter, Thelma Lois, who is now in her early twenties. Mr Mitchell returned to the Townsville area about the time of Cyclone Yasi in 2011. He is reported to have been, in general, a fairly fit man, with strong family beliefs.

For some time, Mr Mitchell had had a problem with alcohol. When he returned to Townsville last year, he initially sought assistance through "Ozcare", and later, with the assistance and support of his niece, Ms Melvina Mitchell, he entered the Stagpole Street Drug and Alcohol Rehabilitation Unit on 31 January. Mr Mitchell remained in the Stagpole Street facility, receiving regular medical assistance and services. The records of the unit suggest he was making good progress until he suddenly discharged himself on 11 April. Sadly, a week later he was dead following a protracted alcohol binge. I offer his family my sincere condolences for their loss.

Events leading up the arrest

Between 11 and 17 April 2012, Mr Mitchell attended on six occasions at the Reverend Charles Harris Diversionary Centre (RCHDC; also known as Gurindal), which provides an alcohol diversion service, and temporary accommodation. During this period it is clear that Mr Mitchell was consuming a substantial amount of alcohol. He was arrested by police on 15 April 2011

for liquor and public order offences, and again on 16 April 2011 for a public order offence. The evidence indicates that on both these occasions, Mr Mitchell was intoxicated, and on the latter occasion, there was an indication that he had been consuming methylated spirits.

At about 7:50pm on the evening of Saturday the 16 April 2011, Mr Mitchell was taken to the RCHDC by the Community Patrol, where he remained until he left at about 6:30am on the morning of 17 April 2011.

At about 11:00am on the morning of 17 April 2011, information was received at the police communications centre from a member of the public that a man was lying face-down on a pathway at the Castletown Shopping Centre.

A two-officer crew from The Strand Police Beat, Constables Jay Higgins and Constable Rachel Waters, attended at Castletown and located Mr Mitchell asleep on a pathway, resting on his backpack. Constable Higgins said he was lying on the grass verge with his feet on the pavement. He had grass over the front of his clothes which led the officer to conclude Mr Mitchell had been rolling around on the ground.

He was able to be woken, and presented to attending police as being "extremely drunk". In Mr Mitchell's back-pack were two "almost full" bottles of methylated spirits. Constable Higgins, the senior attending officer, emptied out the contents of the bottles at the scene. Mr Mitchell did not respond to a request for his name but the officers found his birth certificate in his back-pack. He mumbled something about wanting to find a young girl or a woman but otherwise initially engaged in no meaningful conversation with the officers.

Police then helped Mr Mitchell to his feet, and led him to the police vehicle. Constable Higgins was of the view that without their support, Mr Mitchell would have fallen.

Owing to his condition, police decided to take Mr Mitchell to Gurindal, rather than the watch house. This is an option recognised by the Police Powers and Responsibilities Act which in s378 requires officers to discontinue an arrest for public drunkenness if it is more appropriate that the person arrested be released into a diversionary centre or other place of safety.

When the first-response officers decided to take Mr Mitchell to the diversionary centre, in accordance with their usual practice they first confirmed via the police communications centre that that a place was available for him at the centre and that he was not on a list of persons banned form the centre. They were advised he would be accepted and so they proceeded to that facility.

Upon arrival at Gurindal, Mr Mitchell was taken into the centre by Constable Higgins and a male worker. He was placed on a single bed in the men’s dormitory. According to Constable Higgins Mr Mitchell went to get off the bed but the centre worker pushed him back down and he stayed there.

Constable Higgins then joined Constable Waters at the reception counter so that the officers and the centre employee could complete the paper work necessary to transfer responsibility for the prisoner from the police to the diversionary centre. This was done at 11:30am.

While police were attending to this paperwork, they heard a thump and looked into the dormitory to see Mr Mitchell lying face down on the floor. It was apparent he had fallen from the bed. He seemed uninjured and, unassisted, he scrambled into a sitting position leaning back against the bed. Constable Higgins asked a centre worker, Mr James Blanco if he wanted help to put Mr Mitchell back onto the bed. Mr Blanco responded it would be better to leave Mr Mitchell where he was.

Mr Mitchell had been calling out since soon after he arrived at the diversionary centre. Some of this involved obscene remarks directed at Constable Waters. This caused Constable Higgins to enquire of Mr Blanco as to whether he wanted the officers to take Mr Mitchell to the watch house. Mr Blanco indicated initially that he was content for Mr Mitchell to remain at the centre. However in the next few minutes his level of agitation increased: Mr Mitchell began issuing challenges to fight any and everyone and to engage in obscene activities with an equally wide group. Mr Blanco explained in evidence that he was conscious that he was soon to finish duty at 12:00pm, after which there would be only one male staff member working in the centre. He was worried that one staff member might have difficulty maintaining control of Mr Mitchell. Accordingly, he came to the view that it would be better for everyone if Mr Mitchell went to the watch house. He described this as a joint decision made by him and the police officer.

Admission to the watch house

Mr Mitchell was taken back to the police vehicle, placed inside, and then driven to the Townsville Watch house. The officers observed him sleeping in the pod during the drive. Upon arrival at the watch house at about 11:55am, Constable Higgins, assisted by Civilian Watchhouse Officer Thompson, helped Mr Mitchell from the police van, into the charging area of the watch house. He was there laid on the floor near the charge counter. The cctv recorded vision shows that Mr Mitchell was largely carried into the watch house by Watch house Officer Thompson, who carried most of Mr Mitchell's body weight, allowing his feet to trial.

Constable Higgins said it was obvious that by this stage he couldn't walk by himself and was unable to answer the usual health assessment questions when the first few were asked by the watch house keeper, Senior Constable Benjamin Craig. Accordingly, the watch house keeper entered *"refused*" beside each question but also typed "*Unable/unwilling to walk to charge counter, answer health questions"* into the electronic document.

Mr Mitchell was laid on the floor adjacent to the watch house charge counter. Senior Constable Craig came around from behind the charge counter to look at Mr Mitchell. A brief search was carried out, and Mr Mitchell was then taken

to the "bulk" cell, which was at that time unoccupied. Officer Thompson placed Mr Mitchell in a lateral or recovery position on the cell floor and the searching of him was completed.

Senior Constable Craig carried out a continuing risk assessment upon Mr Mitchell upon his arrival. He recalled that he had had contact with Mr Mitchell at the watchhouse on the previous day, and that it was believed at that time that Mr Mitchell may have been drinking methylated spirits. It was apparent, upon entry, that Mr Mitchell was unable to walk unaided. His speech was difficult to understand, with Senior Constable Craig able to comprehend only an occasional swear word. He was advised Mr Mitchell may have been drinking methylated spirits. This persuaded him that a medical assessment should be carried out on Mr Mitchell.

Senior Constable Craig returned to the watchhouse charge room, and at 12:07pm called the QAS Communications Centre, requesting the attendance of officers for the purpose of assessing Mr Mitchell's medical status. At this point, Constable Craig's assessment of Mr Mitchell placed him in a "high risk" category, to the extent that he commented to his fellow officers that they would have to "keep an eye" on Mr Mitchell. Senior Constable Craig said he made his assessment using appendix 16.1 from the QPS OPMs, a copy of which was stuck on the wall behind the charge counter. Senior Constable Craig continued to monitor Mr Mitchell on cctv until the arrival of QAS personnel.

QAS assessment

Upon arrival at 12:18pm, QAS Officers Selina Chapman and Adam Martston went to the bulk cell and commenced an examination of Mr Mitchell. Watchhouse Officer Thompson was present throughout that examination and after waking Mr Mitchell that officer seems to have been constantly involved in holding him in a lateral position. This was apparently done because Mr Mitchell was recorded as being a “spitter” on the QPRIME system. He was also recorded has having previously been convicted of sex offences. He conformed to this profile by making a sexually explicit comment to QAS Officer Chapman as soon as he saw her.

The examination and recording of Mr Mitchell’s vital signs was principally carried out by Officer Marston. He assessed Mr Mitchell's Glasgow Coma Scale score at 15/15. There was no apparent incontinence nor any external injuries observed. Blood pressure was good. Blood sugar level, pulse rate, and respiratory rate were all within normal limits. On a couple of occasions, Mr Mitchell spat on the floor. The observations were repeated after 4 minutes and remained largely the same. A visual examination of his body looking for signs of injury was undertaken to the extent that the patent would allow it. No trauma was apparent and Mr Mitchell did not complain of any pain. All this led the paramedics to conclude that it would be safe to leave Mr Mitchell in the watch house provided he was closely monitored.

When the examination was completed, at 12:28pm, the QAS officers went to the charge room, where they advised Senior Constable Craig of their assessment. All agree they told him that Mr Mitchell should be kept under observation through cctv, and that the QAS should be called immediately if there was any change in his condition. For the present, however, Mr Mitchell was fit to be held in custody in the watchhouse.

This advice from QAS was important to Senior Constable Craig, as watchhouse keeper. His previous assessment that Mr Mitchell was at high risk was mitigated, and he was of the view that continuing cctv observation, together with periodic visual inspections of Mr Mitchell in accordance with usual watch house practice, would serve to guard against any adverse event. He noted the terms of the advice in the watch house record.

On-going monitoring

Cell checks were then carried out at 12:34pm, 12:51pm, 1:18pm, 1:26pm, 1:31pm, 2:01 pm, and 2:41pm. Townsville watch house practice at that time required individual visual inspection of every inmate no less frequently than every 50 minutes. The checks carried on Mr Mitchell were done at substantially shorter intervals. This came about in part due to the fact that Officer Thompson was during this period escorting other inmates to the shower, and he took the opportunity, in passing Mr Mitchell's cell to make a visual check.

At 3:21pm, Senior Constable Craig commenced a cell check on all inmates, as part of his practice as the end of shift approached. He first checked on Mr Mitchell, and was unable to satisfy himself, by looking through the perspex observation window, that Mr Mitchell's chest was rising and falling. He entered the cell, called out to Mr Mitchell (who was still in the recovery position) and placed his hand on Mr Mitchell's shoulder to shake him in order to rouse him. He noticed a clear slippery substance on Mr Mitchell's shoulder. Senior Constable Craig could not confirm a rising and falling of Mr Mitchell's chest by close inspection. He then left the cell, closing the door behind him, and retrieved a pair of gloves. As he was doing so, Watchhouse Officer Desley Alexander saw him, and asked if he needed a hand with something. Senior Constable Craig advised her that he wasn't sure, and returned immediately to the bulk cell. He was followed shortly after by Officer Alexander, as well as Officer Thompson.

Senior Constable Craig directed Officer Thompson to retrieve the breathing apparatus. While this was being done, the watch housel keeper rolled Mr Mitchell onto his back, and checked for expired air, and a pulse. Neither could be detected. Upon Officer Thompson's return to the cell, CPR was commenced, at the rate of 30 compressions, followed by 2 breaths from the apparatus, with this cycle being continued until the arrival of QAS officers.

QAS resuscitation attempts

QAS staff arrived at the watchhouse at 3:36pm, and immediately commenced to treat Mr Mitchell. Over this period, the police officers continued CPR, as

requested by QAS officers. A total of five QAS personnel attended at Mr Mitchell's cell, including Officer Adam Harders, an Intensive Care Paramedic. The QAS officers said the QPS officers were performing appropriate CPR when they arrived.

Hospitalisation

At 4:02pm, Mr Mitchell was transported to Townsville Hospital. He received treatment in both the Emergency Department, and the Intensive Care Unit. Spontaneous circulation was resumed after 45 minutes of CPR but a CT scan revealed severe diffuse, hypoxic brain injury due to the blood and oxygen supply to the brain being interrupted in the period from the unwitnessed cardiac arrest until the return of circulation. When examined on the morning of 18 April it was apparent brain death had occurred, and Mr Mitchell was certified as deceased at 1:30pm on that day.

A specimen of blood which had been taken from Mr Mitchell upon his admission to the hospital revealed a blood alcohol concentration of 0.358%.

Autopsy results

Two autopsy examinations were carried out on Mr Mitchell's body: the first, by Dr Beng Ong of QHFSS was conducted on 21 April 2011; and the second, at the request of Mr Mitchell's family, was conducted on 9 May 2011 by Dr Johan Duflou, consulting forensic pathologist from Sydney.

Dr Ong suggested a cause of death as:

1(a) Hypoxic-ischaemic encephalopathy
due to, or as a consequence of
1(b) Alcohol toxicity

Dr Duflou opined that the cause of death was:

1(a) Hypoxic brain damage
following
1(b) Cardiorespiratory arrest
due to
1(c) Acute alcohol intoxication

Dr Duflou was also of opinion that a further factor which contributed to Mr Mitchell's death was:

2. Blunt force injury to chest

Both pathologists noted the presence on Mr Mitchell's person of a number of other injuries. Of these, the most notable were fractures to his ribs.

Dr Duflou's report confirmed and discussed a number of rib fractures namely:

- Ribs 2 and 6 at the costochondral junction

- Ribs 3, 4 and 5 in the anterior axillary line
- Cartilages of ribs 5 and 6 at the insertion into the sternum
- Cartilage of rib 5 on the right at the insertion into the sternum

While some of these fractures were consistent with, and possibly attributable to, the extended CPR performed on Mr Mitchell, this was less likely to be the cause of the rib fractures in left ribs 3, 4 and 5 in the anterior axillary line.

Dr Duflou was of the view that (i) bruising to the musculature of the right side of the neck; (ii) bruising to the right cheek; and (iii) bruising in the soft tissues surrounding the fracture of the 4th rib on the left were sustained more than 12 hours prior to death, and that it was reasonably possible that these bruises may have been sustained during, or in the period prior, to his incarceration.

Medical review

Dr Adam Griffin, the Director of the Clinical Forensic Medical Unit, reviewed the evidence pertaining to Mr Mitchell's condition, and the reports of both pathologists. He summarised their effect as follows:

> *Both autopsy reports arrived at the same conclusion: namely the alcohol intoxication caused the systemic collapse that subsequently resulted in brain injury.*

The primary cause of Mr Mitchell's death was this irreversible brain injury caused by deprivation of oxygen: Mr Mitchell stropped breathing, and was for that reason unable to continue the flow of oxygen to his brain, which suffered irreversible damage.

Dr Griffin was also asked to review the assessment carried out by the QAS officers who first attended at the watch house in order to examine Mr Mitchell. Dr Griffin expressed the opinion that with one reservation, it was reasonable and adequate. That reservation related to the apparent absence of an assessment of Mr Mitchell's gait or his ability to self ambulate. In the light of the information that Mr Mitchell was unable to walk without assistance, this assessment of gait may have emphasized the severity of his intoxication. That was not a requirement of the QAS protocols for the examination of intoxicated persons at the time of this incident. However, the Medical Director of the QAS, Dr Stephen Rashford, has advised the court that he agrees with the proposal and that he will issue a clinical directive to all paramedics that henceforth this should form part of their assessments.

Dr Griffin also expressed the opinion that had Mr Mitchell been transported to hospital following the initial QAS assessment, the outcome is likely to have been different. Admission to hospital would have resulted in ongoing observation, including monitoring of Mr Mitchell's airway and oxygenation. Under close observation in hospital, an acute lowering of oxygen would have been apparent, and would have resulted in immediate resuscitative measures and response.

The actions taken by police officers at the watch house, in Dr Griffin's opinion, were compliant with the procedures laid down in the OPM. The request by police for a QAS assessment was the correct action to take in the circumstances.

Dr Griffin noted the QAS advised police Mr Mitchell would be fine to remain in custody, on the understanding that police would contact QAS if any change in his condition took place. In this respect, Dr Griffin noted that no clear guidance was given as to what the police officers were to look for. This, he believed, was a missing component in the process of assessment and review followed in Mr Mitchell's case.

Findings required by s45

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

Identity of the deceased – The deceased person was Herbert John Mitchell.

How he died - While in custody in the Townsville watch house, Mr Mitchell suffered irreversible brain damage due to respiratory and cardiac arrest caused by self-administered alcohol.

Place of death – He died at the Townsville Hospital in Queensland.

Date of death – He died on 18 April 2011.

Cause of death – Mr Mitchell died from global hypoxic brain injury suffered during a cardiac and respiratory arrest caused by acute alcohol intoxication.

Conclusions and recommendations

A number of issues were agreed upon as warranting investigation during this inquest. My assessment of them is set out below as is my recommendations as to how the problems identified might be addressed.

1. **Whether the decision to take Mr Mitchell to the Townsville Police Watch house, instead of allowing him to remain in Gurindal, complied with Gurindal and QPS policy**.

The decision to initially take Mr Mitchell to Gurindal rather than the watch house was consistent with the philosophy underpinning the PPRA Chapter 14 part 4 Discontinuing arrest and the relevant QPS and Gurindal policies.

Gurindal's policies provide that if a person is brought to the centre by police he/she should not be refused admission without the on-call manager being consulted, unless the person is already on an exclusion list.

Mr Blanco did not consult the manager before agreeing with Constable Higgins that Mr Mitchell should go to the watch house. He said the policy was not activated because Mr Mitchell was not refused admission, rather he was evicted for unacceptable conduct soon after being admitted.

The family submit this is an ambiguity that should be reviewed. I accept that when a client is evicted while the admission process is going on some ambiguity as to how the policy applies exists. However, I also consider the on-duty centre workers need the authority to evict violent or threatening clients summarily. Gurindal is a community based organisation managed and staffed by people who are committed to and understand their clients' needs. I don't consider I have sufficient evidence on which to recommend any changes to its policies.

The local SOPs for the drunk diversion program provide that if a person is not admitted to Gurindal because they are too intoxicated, police must call QAS to medically assess the person before they are taken to the watch house.

The Progress Report for 17 April records in entries that relate to Mr Mitchell that he was "*too drunk to stay*" and had "*gone to watch house*." However, I accept the evidence Mr Blanco and Constable Higgins that the real reason Mr Mitchell was removed after he had initially been accepted into the centre was his threatening behaviour, not his level of intoxication.

I consider that was reasonable and the only reasonable alternative then was to take Mr Mitchell to the watch house.

2. Whether the assessment of Mr Mitchell carried out by Officers of the QAS at the Townsville Watch house, prior to the decision to hold Mr Mitchell there, was carried out in accordance with QAS policy and best practice.

A detailed review of the assessment of Mr Mitchell by the QAS officers soon after he was admitted to the watch house was undertaken by the QAS and Dr Griffin. Both concluded that the assessment was in accordance with the appropriate guidelines. Dr Rashford and Dr Griffin also agree those guidelines could be improved by including consideration of a patient's ability to self ambulate. Dr Rashford has indicated to the Court the changes necessary to cause that to occur will be made.

I am of the view that assessment was made in accordance with the current QAS policy. I am also of the view that there could be other changes that may improve its effectiveness. I will deal with those later.

3 Whether the decision to hold Mr Mitchell in the watch house after the QAS assessment, complied with QPS policy.

I am satisfied that once the QAS had indicated Mr Mitchell was fit to remain in the watch house, the decision to keep him there accorded with all relevant QPS policies and was reasonable.

4 Whether the process of checking the welfare of persons held in the Townsville watch house, as applied to Mr Mitchell on the 17 April 2011 (i) *was in accordance with the established policies and procedures of the Queensland Police Service*, and (ii) *was reasonable in all of the circumstances*.

I am satisfied the monitoring of Mr Mitchell in the watch house was carried out in accordance with QPS policy but the fact that he died despite that monitoring strongly suggests those policies are not adequate. I will deal with that below.

5 Whether there is any evidence that any of the injuries which might have contributed to Mr Mitchell's death were caused or inflicted by the act of another person.

There is no clear cause for the fractures to ribs 3, 4 and 5 which may have been caused prior to his admission to the watch house. Similarly, the bruising to the right neck and the right cheek are likely to have occurred earlier.

Mr Mitchell was first seen at Castletown, by a member of the public, lying face down on a pathway, with one hand under his body, and the other behind him. A fall, while in an intoxicated state, is a possible cause for this position, and may have been the cause of some of the injuries.

Although one might normally expect such an injury to have come to attention when he was examined by the ambulance officers at around mid-day, we know he had a blood alcohol level of over 0.4% at that stage and so the pain may have been masked.

I am unable to make a finding as to how those injuries were sustained.

6 Whether there are any grounds to review or amend any policies of the QPS or the QAS with respect to the medical or paramedical review of persons brought to the watch house?

Every death in police custody is cause for concern, especially when, as with the deaths of Mr Mitchell and Mr Ley, the expert medical opinion is they could almost certainly have been avoided had the men been taken to hospital rather than kept in the watch house.

I acknowledge the complexity of the issues that need to be resolved and the magnitude of the problem. Almost 100,000 people pass through Queensland watch houses each year. Many of them suffer from serious chronic and/or acute health complaints. Many of them could pose a danger to themselves or others were they moved to a hospital. Guarding those who pose such a risk would consume large amounts of already stretched human resources of the QPS and create significant disruption in the hospitals.

Obviously then, some cautious discernment is needed when determining which prisoners should be transferred to hospital and which should be kept in watch houses. Police are not medically trained. It was submitted that expecting them to make medical decisions is inappropriate and that medically trained staff should be posted in all of the larger watch houses to make initial assessments and to carry out on going monitoring and re-assessment.

Indeed, if root and branch reform is to be pursued it might be best if police played no role in watch houses in the larger centres. Defendants denied bail could be given into the custody of the correctional authorities who already manage most remand prisoners whose health care needs are met by Queensland Health. Such a change would free up considerable police resources to concentrate on law enforcement and other policing functions while custodial authorities, agencies and/or private sector providers would deliver post arrest custodial services.

However, in the meantime, it may be possible to further improve the way police currently manage the health issues of watch house prisoners. I readily acknowledge that the QPS has over many years given serious attention to the issue and its policies and procedures are far more sophisticated now than they were even a decade ago.

Further, as the evidence in these inquests has canvassed, the Service is continuing to develop new policies with expert assistance. I therefore consider it would be inappropriate for me to make prescriptive, detailed recommendations that might cut across the work that is being done. I will instead limit myself to some observations of principle and articulation of particular problems that the evidence has exposed, confident that those responsible for the on-going work will give due consideration to the matters raised.

1) Consideration of how best to address health issues in watch houses should involve health care providers, especially when changes in QPS policy are bound to impact upon them. Accordingly, it would seem appropriate that the QAS and Queensland Health hospitals be active participants in the development of new watch house policies.

2) The policies of the respective agencies should be complementary. For example, currently the OPMs require police to obtain a written report of treatment provided by QAS officers but QAS policies don’t require one to be given.

3) QAS policies should be developed to cater for the specific needs of watch house prisoner patients. For example, the presumption that busy watch house staff can give the same level of monitoring to an intoxicated prisoner as can be expected of a family member caring for a drunk relative at home seems unrealistic.

4) If health care providers come to a watch house to asses a prisoner it is essential they are made aware of all relevant information known to police. This should be provided in written form to avoid miscommunication and to be available for audit purposes. It would include any information about trauma suffered by the prisoner before coming into custody, blood alcohol levels, history of drug taking, whether he had deteriorated since coming into custody etc.

5) Similarly, when health care providers make an assessment they should communicate that in writing to police if the prisoner is to remain in their custody. Any expectations of how the prisoner's health care needs should be managed in the watch house need to be clearly spelled out for the same reasons. Police can then make an informed decision as to whether they are likely to be able to provide that level of care.

6) Mechanisms for monitoring a prisoners condition need to effectively distinguish between sleeping and unconsciousness and should enable an officer to ascertain whether a prisoner's level of consciousness is deteriorating or symptoms requiring immediate treatment are escalating.

7) The stipulation of observable, clearly defined symptoms or, in appropriate cases, numerical values as a basis for the obtaining of medical attention are more likely to lead to consistent outcomes than expecting officers to respond to poorly understood medical terms and subjective assessments. For example, *"unable to be roused by calling, shaking or sternum rub"* is less likely to be misinterpreted than "*unconscious.*"

8) Electronic record keeping should facilitate compliance with policies. For example, a forcing function that allows an officer to record when a prisoner is unable to answer questions and then requires him or her to indicate what response has been activated to deal with that medical problem is better than encouraging officers to input the closest inaccurate answer from a limited pick list.

9) The proliferation of checklists dealing with similar issues and the contemporaneous circulation of different versions can contribute to uncertainty. Perhaps a more simplified decision tree using the methodology employed in the clinical pathways used by nurses could be adapted and developed.

10) If all officers are to be responsible for ensuring the health condition of their prisoners is appropriately assessed and monitored, it is inevitable on

occasions that more junior officers will need to challenge decisions or inaction by their superiors. Overcoming an authority gradient is difficult in an hierarchical, disciplined organisation but the alternative is based on the false premise that rank, wisdom and insight completely coincide. Junior officers should be provided with the means to by-pass obstacles when safety is at risk without fearing retribution.

11) Mechanisms for assessing the level of compliance with policies are essential. Some of the evidence in these cases suggests aberrant behaviour is not uncommon and that luck has limited poor outcomes.

I close the Inquest.

Michael Barnes
State Coroner
Townsville
14 December 2012