OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Samuel John MILLS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR-3046/04(4)
DELIVERED ON:	29 November 2007
DELIVERED AT:	Cairns
HEARING DATE(s):	25 October 2007, 26 & 27 November 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest, death in custody, correctional centre, suicide, hanging points, funding of prison mental health services

REPRESENTATION:

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Department of Corrective Services:	Ms Tracy Fantin (i/b Dept of Corrective Services)
Cairns & Hinterland Health Service District:	Ms Lisa Evans (Crown Law)

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The *Coroners Act 2003* provides in s45 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, to 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 Samuel John Mills. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

At the time of his death on 12 December 2004, Samuel John Mills was an inmate at the Lotus Glen Correctional Centre (LGCC). When he was discovered hanging in the medical ward, he was not able to be revived. He was only 31 years of age but had struggled with schizophrenia all of his adult life.

These findings seek to explain how the death occurred and consider whether any changes to the policies and/or procedures of the Department of Corrective Services and/or Queensland Health would reduce the likelihood of similar deaths occurring in future or otherwise improve public health and safety.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

At the time of his death, Mr Mills was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*. As such, his death was a "*death in custody*"[1] within the terms of the Act and accordingly, was reported to me for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

[1] Refer s10

[2] Section 8(3) defines "*reportable death*" to include deaths in custody and s 7(2) requires that such deaths be reported to the State Corner or Deputy State Coroner. Section 27 requires an inquest be held in relation to all deaths in custody.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially[9]. This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

[4] s46

[5] s45(5) and 46(3)

[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Mr Mills' death.

At approximately 4.20pm, police from the Mareeba District Criminal Investigation Branch attended Lotus Glen Correctional Centre. The conduct of the investigation was then handed over to police officers from the Corrective Services Investigation Unit (CSIU), a specialist squad within the Queensland Police Service (the QPS) that investigates incidents within correctional centres.

Four detectives from the CSIU attended the medical ward of the Lotus Glen Correctional Centre. They were responsible for co-ordinating the scenes of crime officers who came to the prison, arranging for the medical ward and surrounding areas to be photographed and interviewing relevant witnesses.

A post mortem examination was performed by Dr Williams at the Cairns Base Hospital the next day.

The Department of Corrective Services commissioned an independent review of the circumstances surrounding the death of Mr Mills. I have had regard to their report and have been assisted by it.

As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or that the authorities have failed in their duty to properly care for the prisoner. It is therefore essential even when a death appears at the outset not to be suspicious, the investigation is thorough and rigorous. I am satisfied that as a result of the contribution made by the various bodies which inquired into this case, including the evidence obtained at inquest, the circumstances of the death have been sufficiently scrutinised to enable me to make findings on all relevant issues.

The inquest

A pre-hearing conference was held in Brisbane on 25 October 2007. Ms Bryson was appointed Counsel Assisting. Leave to appear was granted to the Department of Corrective Services and Queensland Health. The family of Mr Mills was not separately represented, however they consulted with those assisting me before and throughout the inquest.

The inquest proceeded over two days commencing on 26 November 2007. Fourteen witnesses gave evidence and 120 exhibits were tendered. I was greatly assisted by the submissions made by the legal representatives of those granted leave to appear. I would also like to acknowledge the refreshing

[10] (1990) 65 ALJR 167 at 168

candour of the parties who participated in this inquest. It seemed to me that the departments concerned were prepared to acknowledge some shortcomings of service delivery and exhibited a willingness to explore avenues for improvement. Not only is that in the public interest, I am sure it assisted the family of Mr Mills to know that the responsible agencies are seeking to reduce the likelihood of similar deaths.

I take this opportunity to express my condolences to his mother, brother and other siblings. I am sure that on occasions Mr Mills' illness was very distressing for those close to him and I expect they often feared his turbulent life would have a sad end.

The evidence

I turn now to the evidence. Of course I can not summarise 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.

Family Background

Mr Mills was born in Sydney, New South Wales on 12 July 1973. He had three siblings, two younger brothers and one younger sister. Mr Mills had a love of sports and was a good musician.

Suzanne Hawke, Mr Mills' mother, says her son had a problem with cannabis from an early age. She first took him to a psychiatrist when he was about 12 years old however no formal diagnosis was made at that time. He began to get in trouble with the police soon after and at the age of 15 he ran away from home.

Criminal History

Mr Mills had criminal convictions in both New South Wales and Queensland. His offending in New South Wales commenced in 1989 at a time when he was 15 years of age. In both Queensland and New South Wales, Mr Mills' offending behaviour predominantly related to vagrancy and dishonesty offences. He has been sentenced to periods of imprisonment in New South Wales and has spent time in custody in Queensland as a remand prisoner. At the time of his death, Mr Mills was on remand for a number of vagrancy and street type offences having been refused bail in the Cairns Magistrates Court on 1 October 2004.

Psychiatric History

I have set out below in some detail a summary of the numerous admissions and outpatient treatments accessed by Mr Mills during the 10 years preceding his death. During that time he was an inpatient on 21 occasions in eight institutions. I detail the contact with mental health services for a number of reasons. First, I understand that his family lost contact with him for substantial periods and it may be of interest for them to know the extent to which attempts were made by the responsible agencies to assist Samuel. Second, it demonstrates the difficulty faced by schizophrenia sufferers and those

seeking to assist them. It is clear from the summary that Mr Mills' insight into his condition fluctuated; at times he actively sought treatment while on other occasions he absconded from places where he was being given it. Even though no long term "cure" was ever achieved, it is not the case that he was denied treatment or his condition ignored.

He first presented to the Prince of Wales Hospital in New South Wales on 12 November 1993. At this time, he was diagnosed as suffering from a drug induced psychosis and was admitted for a period of two weeks and prescribed Melleril.[11] He was readmitted a couple of weeks later having overdosed on his prescription medication. He admitted to staff that his overdose was not accidental.

Mr Mills was subsequently admitted to hospital in New South Wales on three occasions in the next two years. On each occasion he was kept as an inpatient for a week or two until his psychosis was stabilised with antipsychotic drugs.

His treatment in the Queensland mental health system commenced in September 1997 at the Toowoomba Base Hospital. Mr Mills was diagnosed with chronic schizophrenia and was prescribed Flupenthixol Deaconate.[12] Later that month, Mr Mills presented to the Nambour Hospital where he was admitted for a period of two weeks. At this time, he was prescribed Haloperidol.[13] Some eight days after discharge he again presented to the Toowoomba Hospital requesting admission. He was admitted to the Baillee Henderson Unit of the Toowoomba Hospital for a period of five days.

During 1998, Mr Mills had extensive contact with mental health services in Toowoomba, Townsville, Cairns and Tully. For example, in January 1998, he was admitted to the Toowoomba Hospital after experiencing an acute relapse of chronic schizophrenia. He was again prescribed Flupenthixol Deaconate which is often prescribed to patients who are non-compliant with medication. After seven days, he was discharged and referred to the community mental health service for follow up.

On 15 February 1998, Mr Mills was again admitted to the Townsville Hospital suffering an exacerbation of his psychiatric symptoms. He spent approximately one month in hospital and was treated with the antipsychotic medication Zuclopenthixol Decanoate. At this time, Mr Mills became a regulated patient under the Mental Health Act as he was assessed as presenting a danger to himself.

[11] Melleril was one of the first antipsychotic therapies available for the controlling of severe symptoms of schizophrenia. The production of Melleril was discontinued worldwide in June 2005 as it was superseded by improved schizophrenia medications.
[12] This is a typical or classical antipsychotic medication prescribed in the treatment of schizophrenia administered intravenously. It is usually required to be taken every 2-3 weeks.
[13] Haloperidol is from the same family of antipsychotic medication as flupenthixol deaconate and is also administered intravenously.

On 19 April 1998, Mr Mills attended the Accident and Emergency Department of the Cairns Hospital. He presented in a paranoid state, his appearance was dishevelled and he was delusional. A decision was made by the treating team that an order should be obtained to detain Mr Mills in the hospital.

Over the next few months, Mr Mills continued to abscond from the Cairns Hospital and would be returned by police. In September 1998, he was arrested in Innisfail in relation to vagrancy offences and a charge of going armed in public to cause fear and was remanded in custody to the Lotus Glen Correctional Centre (LGCC). During his time on remand, Mr Mills was seen by Dr Paul Trott, a consultant psychiatrist. Dr Trott assessed Mr Mills to be acutely psychotic and arrangements were made for him to be transferred from the LGCC to the High Dependency Unit of the Cairns Hospital on 30 September 1998.

It immerged during the course of the inquest that during this period of custody at the LGCC, Mr Mills was assessed as a high risk inmate and was placed on stringent observation conditions. It appears records relating to this period of time were not kept on Mr Mills' correctional file and as a result this information was not available to staff responsible for Mr Mills' welfare in 2004.

Following his transfer to the High Dependency Unit of the Cairns Hospital, Mr Mills was commenced on a trial of Clozapine. He was classified as a regulated patient under the Mental Health Act as it was felt he could not give consent for treatment. On 5 October 1998, Mr Mills absconded from the hospital but presented to the Tully Hospital four days later requesting that he be readmitted to Cairns.

Mr Mills remained a patient in the High Dependency Unit until 14 October 1998 when he absconded again during escorted leave. He was subsequently returned to the LGCC on 21 October 1998 and was then transferred back to the High Dependency Unit at Cairns Hospital.

Mr Mills was transferred to the Townsville Hospital on 13 November 1998 following a recommendation from Dr Bayley, a Consultant Psychiatrist in Cairns that he required a prolonged admission to a long stay psychiatric facility. He subsequently absconded on 30 December 1998 while on escorted leave.

On 6 January 1999, Mr Mills was arrested in relation to unpaid fines and was required to spend a total of 27 days in custody. He was imprisoned at the Rockhampton Correctional Centre. Upon being received into custody, an intake assessment was conducted which deemed Mr Mills an "at risk" prisoner. The basis of this assessment was that he presented with extensive scarring from self inflicted wounds and that his thought processes were disordered. Further, during the intake process, Mr Mills disclosed he had previously been treated at the Cairns Hospital and accordingly, the relevant medical records were obtained from Cairns.

Mr Mills was referred to a psychologist who recommended he be the subject of one hour visual observations which commenced immediately. It was found that Mr Mills was psychotic and in need of urgent psychiatric care. The records indicate he was prescribed Rispiridone, Olanzapine and Largactil.

It appears this information was available to staff at LGCC during the time Mr Mills spent in custody in 2004 as the medical records for the Lotus Glen Correctional Centre contain copies of the progress notes and immediate needs assessment conducted in 1999 at Rockhampton. However, it clearly did not come to the attention of the relevant health care professionals, and therefore was not considered as part the numerous assessments undertaken during that period.

He was admitted to the Cairns Hospital for continued treatment on 23 February 1999 and was in turn returned to the Townsville Hospital on 25 February 1999.

On 8 April 1999, with respect to Mr Mills' outstanding criminal charges from Innisfail, the Mental Health Court found that he was of unsound mind at the time he committed the offences and that he was unfit for trial. Accordingly, a forensic order[14] was made and he was detained in hospital.

It seems Mr Mills progressed considerably during his hospitalisation. He continued to be trialled on Clozapine and via a structured community re-integration program, he was reclassified as a full time outpatient in April 2001.

Throughout 2002 and 2003, Mr Mills continued to be under the care of the Cairns Community Mental Heath Service and his forensic order was periodically reviewed and confirmed. His prescription of Clozepine continued, he appeared to be compliant with his medication and his mental state was somewhat stable. He continued to be managed by his case worker, Mr Bonome and would regularly attend the day program offered at the Cairns Community Mental Health Service.

Mr Bonome became Mr Mills' case worker in June 2003. During 2001 and 2002, Mr Bonome also had contact with Mr Mills' via the Community Mental Health Service in Innisfail.

However, in December 2003 Mr Mills became unstable and non compliant with his medication. He was brought to the Emergency Department of the Cairns Hospital by ambulance. He presented in a drowsy state with slurred speech. The medical records indicate that Mr Mills was not taking his medication as required. For example, it seems he had not taken his medication for a few days but then took an excessive dose. Mr Mills was discharged and was to be followed up by the Community Mental Health Service.

[14] pursuant to s 36 of the Mental Health Court Act

Psychiatric History during 2004

On 5 January 2004, Mr Mills failed to attend at the Cairns Community Mental Health Service to receive his medication; a condition of his forensic order. Accordingly, having regard to his status as a forensic patient, the relevant authority was obtained to allow the police to apprehend Mr Mills and return him to hospital. This occurred on 7 January 2004 and he was admitted to the High Dependency Unit of the Cairns Hospital.

Mr Bonome, Mr Mills' case worker, recalled that when he saw him in the High Dependency Unit on 8 January 2004, he was obviously "*very sick*" and suffering from delusions. On 12 January 2004 during a review of his forensic order, the Mental Health Review Tribunal confirmed the existing order however revoked the condition allowing limited community treatment. The effect of this new order was that Mr Mills was detained as an inpatient in hospital. Following a marked improvement in Mr Mills' mental state, his entitlement to limited community treatment was reinstated on 22 January 2004.

While an inpatient and because of his failure to comply with his medication requirements, his treating team modified his medication from Clozapine to Clopixol, which is an anti-psychotic medication administered intravenously each fortnight. This treatment regime continued for some months with his dosage being increased on 7 April 2004 in response to his deteriorating mental state.

An improvement was noted in Mr Mills' presentation on 14 April 2004 however his condition continued to fluctuate. On 13 June 2004, Mr Mills attended the Cairns Police Station and requested that they "*turn their radios off*" because they were "*controlling his brain.*" He was transported to the Cairns Hospital and admitted as an inpatient until 24 June 2004. During his admission, his treating team modified his medication and changed his prescription to Haldol, a drug also administered intravenously, fortnightly.

Mr Bonome also held concerns about Mr Mills' ability to manage his own finances. It seems Mr Mills frequently spent his pension money very quickly, probably on illicit drugs, not leaving money for essential items such as food and personal items. At about this time, Mr Bonome contacted the Public Trustee on behalf of Mr Mills' seeking their assistance. Control of Mr Mills' pension funds was subsequently handed over to the Public Trustee.

On 18 July 2004, Mr Mills was located by police trespassing at the Cairns airport. The material indicates that Mr Mills jumped the fence near the domestic terminal and then walked from the domestic to the international terminal. He was spoken to by police and explained that his reason for being at the airport was that he was "*looking for work*". The circumstances of this offence were discussed with Mr Mills by Dr Woolridge in October 2004 and Dr Woolridge formed the view that Mr Mills was, at the time he committed this offence, of "*unsound mind*" in the legal sense.

Throughout August 2004, Mr Mills continued with Haldol and it was noted that his behaviour seemed to stabilise and he was no longer suffering delusions. He remained medication compliant during this time.

Mr Bonome gave evidence that Mr Mills was a difficult patient to manage, often failing to comply with his medication regime. According to Mr Bonome, Mr Mills' did not believe he suffered a mental illness and resented being the subject of a forensic order.

On 30 September 2004, Mr Mills attended the Cairns Community Mental Health Service. While Mr Mills was socialising with other consumers, members of the Queensland Police Service attended and indicated to Mr Bonome that they wished to speak to Mr Mills. It appears from the material that Mr Mills had failed to appear in court as required on at least one occasion and was wanted in connection with three break, enter and steal offences committed at the Cairns Convention Centre.

Mr Bonome administered the medication Mr Mills was due to receive that day and advised him that the police wished to speak to him. Mr Bonome recalled that Mr Mills appeared calm and co-operative and after a short period, he accompanied police to the station.

The following day Mr Bonome contacted the watch house and was informed that Mr Mills would remain in custody until 27 October 2004. As a result, he contacted the Crisis Assessment and Treatment Team (CAAT) to advise them of Mr Mills' presence in the watch house.

On 4 October 2004, Mr Bonome was informed that Mr Mills would be transported to the LGCC that day. Accordingly, he contacted Kellie Thackeray a forensic mental health worker employed by the Tablelands Community Mental Health Service. Her principle duties were the assessment of mental health patients incarcerated in the LGCC. He provided her with background information in relation to Mr Mills' diagnosis, prognosis and medication regime. Ms Thackeray was informed that Mr Mills was next due for his Haldol injection on 12 October 2004. Progress notes and previous psychiatric reports were also provided via facsimile to Ms Thackeray. Mr Bonome had no further contact with Mr Mills

I wish to acknowledge the professional and compassionate care Mr Bonome provided to Mr Mills.

The Management of Mr Mills at the Lotus Glen Correctional Centre

On the day of his arrival at Lotus Glen, Mr Mills was assessed by Kornelia Maraczy, a registered nurse and Bill Clarke, a counsellor. He disclosed that he suffered from schizophrenia and that he had last been medicated on 28 September 2004. When questioned in relation to his mental state he did not disclose any thoughts of self harm nor did he indicate he was feeling depressed. He indicated that he was a regular user of heroin, amphetamines

and marijuana. Ms Maraczy therefore appropriately recorded that Mr Mills "*is withdrawing from opiates."* A notation in the progress notes indicates that Mr Mills stated that "*he will not harm himself whilst in LGCC*". Mr Clarke recorded that a full induction took place and that there was "*no problems*" identified but in view of his history of mental illness Mr Mills was referred for review by the visiting psychiatrist, Dr Woolridge.

This occurred the following day when Mr Mills was seen by Ms Thackeray and Dr Woolridge. The consultation was of at least one hour and Mr Mills' prescribed medication, Haldol was continued.

On 7 October 2004, Mr Mills presented to nursing staff expressing concerns that his "*psych management is not being carried out*". These concerns were referred to Ms Thackeray who advised that Mr Mills was not due for his depot medication for another week.

On 12 October 2004 Dr Woolridge also prescribed Cogentin, he presumes in response to advice that Mr Mills was suffering side affects of Haldol, namely tremors.

On 20 October 2004, Mr Mills again presented to staff advising them that he no longer needed his medication as he was "*no longer sick*". He was advised that he should continue to take the medication he was being prescribed or he would run the risk of the tremors returning. Further, it was suggested to him that he should discuss issues regarding his medication with either Dr Woolridge or KellieThackeray.

When Mr Mills was seen by Ms Thackeray on 22 October 2004, he was in a distressed state. It was reported that he had been in an altercation with another inmate and he was shaking visibly. Ms Thackeray contacted Dr Woolridge who prescribed Diazepam which would have a sedative effect. After the drug was administered, Mr Mills appeared to settle and returned to his cell.

Mr Mills was transported to the Cairns Watchhouse on 25 October 2004 to attend court. He was held in watchhouse in Cairns until 28 October 2004 when he was returned to Lotus Glen Correctional Centre. An entry by Dr Woolridge on 26 October 2004 indicates that Mr Mills was unable to be seen as he was at court and that he required a *"review ASAP*".

On 2 November 2004, Mr Mills was seen by Dr Woolridge and his medication was varied to include Olanzapine and Diazapam. Dr Woolridge gave evidence that on this occasion, Mr Mills presented as very unwell with delusional and paranoid thoughts. Olanzapine was prescribed as it was thought that a fast acting anti-psychotic was required. The management plan was to keep him in the hospital and for Dr Woolridge to review him weekly. Dr Woolridge gave evidence that he did not have any concerns about Mr Mills being kept in the hospital at LGCC rather than being transferred to Cairns Hospital as he thought Mr Mills could be adequately managed there.

Dr Woolridge again saw Mr Mills on 9 November 2004 where he again presented with some psychotic symptoms although he had improved markedly. Dr Woolridge's notation reads "*this is probably as good as Sam gets."* On 23 November 2004, Mr Mills was again reviewed and was observed to be displaying extra-pyramidal symptoms which are a side affect of Cognetin. Dr Woolridge decreased his dose in an attempt to control these.

When reviewed on 30 November 2004, Dr Woolridge assessed his mental state as "*good*" and noted that the reduction in the Cognetin "*appeared to be effective*." His medication regime was continued and Dr Woolridge indicated that he didn't need to see Mr Mills for another four weeks.

Mr Mills was reviewed on two subsequent occasions by Ms Thackeray. On 3 December 2004, Mr Mills' termors remained settled and he reported sleeping well and having a good appetite. On 10 December 2004, Ms Thackeray noted that Mr Mills' mental state was "*stable"* and that he "*states he has no issues or concerns. No evidence of self harm or suicidal ideations*".

Events of 12 December 2004

At about 9.30am on 12 December, Mr Mills attended the medical centre at the LGCC as he was due to receive his Haldol injection. This was administered by Ms Bakos, a registered nurse employed at the centre. Afterwards, Mr Mills requested that he be allowed to remain in the medical ward rather than return to his cellblock. He explained that his unit was noisy and he needed some time out. Ms Bakos asked Mr Mills whether he was going to hurt himself to which he responded "*no*".

After consultation between nursing staff and corrective services officers, it was decided to allow Mr Mills to remain alone in the six bed ward in the medical centre. He was only in there for about ten minutes before one of the nurses suggested it might be better for Mr Mills to share the two bed ward with another prisoner who was in there for medical observations. Mr Mills accepted this offer and was moved at about 10.00am.

At about 10.45am, Mr Mills buzzed the corrective services officer on duty and requested that he be allowed to return to the larger cell. He told this officer, Mr Feros, that he wanted to be on his own. His request was again discussed between Mr Feros and nursing staff and he was moved back to the larger ward. Again, Ms Bakos recalls enquiring with Mr Mills as to whether he had thoughts of self harm or suicide; Mr Mills' response was "*No miss".*

Mr Feros gave evidence that after moving Mr Mills to the larger cell he delivered him lunch at about 11am. At this time, Mr Mills requested some additional bread which was provided. Mr Feros recalls Mr Mills *"appeared grateful;"* certainly nothing about his demeanour led Mr Feros to suspect that Mr Mills was at risk of self harm. Mr Feros said that over the ensuing couple of hours he checked on Mr Mills frequently.

At about 1.00pm, Mr Mills again buzzed Mr Feros and asked if he could be let out of the ward for a cigarette. Mr Feros said that Mr Mills showed him a hand rolled cigarette but he did not have a lighter. Mr Feros asked the two nurses, Ms Bakos and Ms Maraczy, who were outside the building if they minded Mr Mills joining them and borrowing their lighter. When they responded that they did not mind, Mr Mills was allowed to join them.

Ms Maraczy, Ms Bakos and Mr Mills were outside the medical unit for about fifteen minutes. The nurses observed that he maintained good eye contact and did not appear to be upset, angry or unsettled. They talked generally about his upcoming court appearance and he indicated that he expected to get a short sentence.

Mr Mills said that he did not want to return to his usual cell and would prefer to be transferred down to the Townsville Hospital. It was explained to him that no movements could occur as it was a Sunday but that he could stay in the medical unit overnight and it could be "*sorted out*" tomorrow. Ms Maraczy recalls that Mr Mills seemed satisfied with this plan. Ms Maraczy gave evidence that in response to an inquiry she made Mr Mills denied any thoughts of self harm. She says she did this not because he was exhibiting any symptoms that alarmed her but just because she knew he was in the ward alone and that the room was not easy to see into from the outside.

At about 1.15pm, Mr Mills was returned to the six bed medical ward. The evidence of Mr Feros was that he recalled checking on Mr Mills "*about every fifteen minutes"* but could not say with certainty at what time he last saw Mr Mills alive. He says that on the occasions that he saw him, Mr Mills was either sitting on his bed or walking around the room. Ms Maraczy gave similar evidence.

The ward was locked and no one other than Mr Mills was inside it.

The death is discovered

At approximately 2.10pm, Mr Feros approached the six bed ward to offer Mr Mills a cup of tea. Initially, upon looking through the observation window in the door he could not see Mr Mills. On craning his neck and looking to the far left of the room, he saw that Mr Mills was hanging for the bars that secured the louver windows. Mr Feros immediately yelled to the nurses for assistance, unlocked the door and entered the ward.

Mr Feros stood on a chair and climbed up the ladder like bars so that he could cut Mr Mills down. Ms Bakos was holding Mr Mills up, attempting to support his body weight. Mr Feros took a knife from his belt and cut the ligature that was tired around the bars and Mr Mills' neck. A portable fan had been jammed between the bars and its cord used to secure a knot around the bars and Mr Mills' neck.

Ms Maraczy and Ms Janke, also a registered nurse, had brought the emergency trolley into the ward. Mr Mills was laid on the floor. Ms Bakos

recalls checking for a pulse but being unable to find one. Further, she recalls observing that Mr Mills' pupils were fixed and dilated, his tongue was protruding, he appeared very cyanotic and that he was incontinent of urine.

Ms Maraczy and Ms Bakos commenced CPR with manual chest compressions until the oxy viva machine was set up. Once this was in place, Ms Janke commenced pushing in the air bag that was attached to the oxy viva machine and one of the corrective services officers took over the compressions. The automatic external defibrillator indicated no signs of heart movement and so CPR was continued for approximately 15 minutes however Mr Mills was unresponsive.

The Queensland Ambulance Service was called very soon after Mr Mills was found hanging. Ambulances officers arrived at the medical centre at 2.36pm and connected a "heart start defibrillator" which also indicated no electrical activity within the heart on leads one, two and three. Life extinct was declared and the body of Mr Mills was formally identified by Mr Feros.

The investigation detailed earlier then commenced.

Autopsy evidence

An autopsy was conducted by Professor David Williams, an experienced forensic pathologist, at the Cairns Hospital on 13 December 2004. The autopsy disclosed no significant natural disease and Dr Williams expressed the view that in his opinion the cause of death to be self inflicted hanging. Professor Williams gave evidence that the ligature mark was consistent with hanging and inconsistent with manual strangulation. He also said there was no injury to the larynx or any other injury indicating any third party involvement in the death.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have described above my findings in relation to this last aspect of the matter, the manner of death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars of the death.

Identity of the deceased	The deceased person was Samuel John Mills
Place of death	He died in the medical unit of the Lotus Glen Correctional Centre
Date of death	He died on 12 December 2004
Cause of death	He died from self inflicted hanging.

Concerns, comments and recommendations

Section 46 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.

I am persuaded that despite vigilant inquiry, the staff supervising Mr Mills on the day of his death had no basis to suspect that he was in imminent risk of self harming. All of the professional staff who had contact with him in the days before his death including the psychiatrist and the mental health workers say they were very surprised and indeed some were very distressed by the death. In those circumstances, the supervision of Mr Mills on the day of his death was adequate, indeed to institute more intrusive observation of him, when he had asked to stay in the medical ward for some "time out" would have been unkind, unwarranted and potentially increased the risk of him self harming.

I am also satisfied that when Mr Mills was discovered hanging staff responded appropriately and that there was nothing more they could have done to save his life.

Notwithstanding those findings, because the bases for a coroner to make preventative recommendations are expressed as alternatives, this function may be exercised even if the coroner finds that the death could not have been reasonably prevented. He or she may still comment on things connected to the death that relate to public health and safety or the administration of justice.

The circumstances of Mr Mills' death, in my view, raise the following issues for consideration from this perspective:-

- Were Mr Mills mental health issues adequately managed whilst he was in custody at Lotus Glen Correctional Centre;

- Would any changes to QCS policies or procedures improve the health and safety of prisoners suffering mental illness?

The incarceration of the mentally ill

Before turning to those issues I will make some general observations about the unhappy interface between those suffering from mental illness and the criminal justice system.

Schizophrenia is a debilitating disease that may affect up to one percent of the population. Its severity and symptoms vary widely. Many sufferers are relatively stable for long periods and live productive and fulfilling lives. For a minority, however, the disease causes constant turmoil with persistent disruptive symptoms. These individuals may fluctuate between florid psychotic periods when they may pose a serious risk to themselves or others to relatively more stable periods when they are anxious and disorganised in their thought pattens but able to live with their auditory and/or visual hallucinations.

When the illness is in an acute phase involuntary hospitalisation and anti psychotic and tranquilising drugs are usually essential to de-escalate the psychosis. A continuation of some pharmacotherapy is almost always required along with psycho-therapy and a high level of social support.

Some sufferers of schizophrenia also have varying levels of personalty disorder; many do not comply with their medication regimes and abuse illicit drugs. They are frequently highly mobile. Community mental health services are staffed by many dedicated professionals but crushing workloads lead to a high turnover which combines to deny a continuity of care; an essential ingredient of a therapeutic alliance.

All of these factors can contribute to limited treatment outcomes. As a result, a significant number of schizophrenia sufferers have very low levels of social engagement and exhibit aberrant and anti-social behaviour. This makes employment almost impossible and homelessness and low level criminal offending more likely. Disorganised lifestyles make complying with community based court orders problematic and there is rarely an ability to pay fines. Repeat offending, a failure to comply with bail or other court orders lead to a disproportionate number of schizophrenia sufferers being imprisoned. This is the pathway that led Samuel Mills to the LGCC.

Community mental health services have been grossly under funded since the 1980s when they replaced mental health residential institutions as the primary mode of service delivery. It is bleakly ironic that this well intentioned reform has resulted in a significant proportion of the mentally ill being now housed in other state run institutions, namely prisons. Indeed estimates of the proportion of prisoners suffering from mental illness varies from 20 to 50 percent depending upon which mental illnesses are included. The magnitude of this problem is brought into stark relief by the government's estimate that the state's prison population will nearly double in the next ten years.[15]

Alarmingly, as the State Director Queensland Forensic Mental Health Services candidly acknowledged *"(h)istorically, minimal services have been provided for prisoners with mental illness*."[16] Dr Grant goes on to suggest that this injustice has been recognised and responded to. However, as I shall detail later, he also accepts that very little has actually changed at LGCC. Before examining the current situation in that prison I will first make some observations about the mental health care provided to Mr Mills when he was incarcerated there in 2004.

The management of Mr Mills by LGCC mental health staff

As detailed above Mr Mills was assessed by a nurse and a counsellor the day he arrived at the prison and in view of his long history of mental illness, he was identified as in need of a review by the visiting psychiatrist.

[15] Exhibit G7 attachment 5 p3
[16] Exhibit G7 p1

This happened the following day when Mr Mills also saw Ms Kellie Thackeray, the forensic mental health worker, who had been sent information about him by Mr Bonome.

Thereafter Dr Wooldridge reviewed Mr Mills on five occasions in the ensuing six weeks and Ms Thackeray saw him at least weekly. When she was concerned about his condition following an altercation with another prisoner she was able to discuss her concerns with Dr Wooldridge over the telephone and sedatives were prescribed.

Mr Mills' medication was constantly adjusted until Dr Wooldridge considered, having regard to the description of his symptoms in the Cairns Community Mental Health Service notes, that Mr Mills was "*as good as he gets."*

Dr Wooldridge said in evidence that ideally he would have liked to have seen Mr Mills more regularly when he was in an acute phase and that this might have enabled his medications to be adjusted more speedily. Dr Wooldridge also acknowledged that in view of his workload, effective psycho-pharmacotherapy was all he could reasonably pursue; whereas to further advance the management of Mr Mills entrenched symptoms, psychotherapy would also be needed.

I consider that the nurses, counsellors, mental health workers and the visiting psychiatrist did all that could be reasonably expected to respond to Mr Mills very considerable mental health needs. He was fortunate to have such expert, experienced and dedicated professionals to care for him.

Those staff members were not aware that Mr Mills had previously been assessed as being at risk of self harm by mental health workers at Rockhampton Correctional Centre and LGCC in 1999 and 1998 respectively. Had they been, it is likely that more attention may have been paid to the issue initially. However, I am not persuaded that would have resulted in his being treated any differently, certainly not two months later when he had shown no indications of being at risk in the intervening period.

Since Mr Mills' death an electronic information file management system has been introduced across the department. The Integrated Offender Management System (IOMS) provides a more complete profile of prisoners, the relevant parts of which are able to be accessed by the various departmental staff with responsibly for managing prisoners. An important feature of the system is the summary page which provides basic information and enables the posting of flags or warnings seen by anyone opening it. Included among those flags are notification of current self harm/suicide risk and a known history of such.

It became apparent during the inquest however, that back capturing of this data has not been complete. If the system is to be effective information held by the department on paper files relating to current of potential prisoners needs to be uploaded.

Recommendation 1 - Audit of paper files for "at risk" information

I recommend that the Department of Corrective Services audit its hard copy files to ensure records of previous self harm attempts are added to the IOMS

Elimination of hanging points

Suicide is by far the single biggest cause of death among prisoners accounting for 46% of all prison deaths. In raw numbers, in the period 1980 to 2005, 520 prisoners in Australia took their own lives while the second most common cause of death was natural causes which accounted for 403 deaths. Prisons are viewed by many as dangerous places, yet in the same period homicide caused only one tenth as many deaths as suicide.[17]

Hanging is by far the most common mechanism by which prisoners take their own lives accounting for 90% of all cases.[18]

Research has consistently shown that suicide in many cases is an impulsive action. It is not the case that if obvious opportunities to commit suicide are removed, all potential victims will find another way. Studies have shown that the placing of even minimal barriers will discourage numerous attempters. In prison this is even easier to effect as prisoners have such limited access to other means – this is why hanging is so often the method used: it is almost the only mechanism available.

The inquest was advised that the ward in which Mr Mills died is no longer used for housing prisoners other than for very short period of time. This is fortunate as in addition of having numerous hanging points its design also made observation of prisoners very difficult.

The two bed ward remains in use however and it too has bars from which prisoners can affix ligatures. Removal of them would be consistent with the undertaking the State Government made to implement a recommendation of the Royal Commission into Aboriginal Deaths in Custody to the same effect.

The inquest received evidence that a major redevelopment of LGCC is planned. Stage 1 provides for the redevelopment of the medical centre. The design is suicide resistant. Stage 2 apparently involves modification of existing cells by the sealing of exposed bars and removing other hanging points. Those plans are of course to be supported but as has frequently been observed with government planning, there is many a slip twixt cup and lip.

The department has embraced the concept of elevated base line risk but it is extremely difficult to distinguish between those who are at chronic risk of self harm and those whose risk is acute. I commend the Department for continuing to grapple with these difficult issues. Mr Mills would have been identified as a prisoner with an elevated risk - his mental illness, drug abuse and previous self harm would have brought him within that category. But this does not

[17] *Joudo J., "Deaths in custody in Australia : National Deaths in Custody Program annual report 2005"*, Australian Institute of Criminology*, 2006, 65*

[18] ib id, 64

mean that he necessarily would have been managed differently. It is of course impossible and indeed would be undesirable to place all prisoners with an elevated base line risk on observations. Therefore, it is essential that all cells be made as safe as possible. As long as hanging points remain lives are at risk.

Recommendation 2 – Removal of hanging points

I recommend that the State Government immediately make available sufficient funding to enable the removal of the exposed bars and other hanging points in all cells at the LGCC.

The provision of mental health services in LGCC

At the time of Mr mills death the only specialist mental health services provided in LGCC was a once a week visit by Dr Woolridge, a private practitioner who was contracted to provide a four hour session. It is apparent that his high sense of social responsibility led him to frequently exceed this hourly limit. Indeed he also made himself available on weekends for telephone consultations even though he was only obliged to provide this service during the week. The only qualified assistance he had was one forensic mental health worker. I don't want any of my comments to be misconstrued as criticism of those individuals. As I have already said I consider the care they gave Mr Mills was of a high standard. However, all of those who gave evidence on the issue candidly accepted that these human resources were insufficient to cater for a prison with an average population of around 400 people. Dr Woolridge indicated that he would have liked to have seen Mr Mills and others more frequently than once per week when they were acutely unwell and that this limited his effectiveness. In his opinion, he would need two or three days per week to provide an adequate standard of care for all of those who needed it.

As indicated earlier, there has been a substantial increase in funding of prison mental health services since Mr Mills' death. Further, the Tablelands and Cairns heath service districts have amalgamated. Notwithstanding these changes, the level of service to the LGCC has not increased. There is still only one paramedic, a psychiatric nurse and one session per week by Dr Woolridge to attend to the mental health needs of 400 prisoners. Another allied health clinician's position and two indigenous mental health workers positions have been created but none of these has been filled due recruitment difficulties.

The government has committed to transferring responsibility for the provision of all health care, including mental health, in prisons from the Department of Corrective Services to Queensland Health. It is easy to accept that the greater opportunity for the integration of mental health care through all stages - pre and post custody, staff development and mentoring and seamless case management has the potential to improve the quality of the health care provided to prisoners. Dr Woolridge highlighted the desirability of a co-ordinated multi- disciplinary approach that will obviously be easier to pursue when all of the disciplines are employees of the same department. The

creation of a forensic mental health hub in Cairns will complement these changes.

However, the current proposal only envisages the Cairns forensic psychiatrist's position being funded at 0.5 FTE. This will make it very difficult to fill. Further, it provides no capacity to service the LGCC. That prison's redevelopment will see its population increase by 300. It is patently obvious that such a population will need the equivalent of a fulltime psychiatrist. It would be a backwards step to lose the services of Dr Woolridge who has demonstrated admirable professional commitment in demanding circumstances.

Being aware of the severe shortage of all medical specialists in rural Queensland I expect Dr Woolridge has a very busy practice and has no desire to become a full time Queensland Health employee. In my view, the obvious solution is to increase the Cairns forensic psychiatrist position to 1 FTE while continuing to contract Dr Woolridge for one session per week. The continuity of care and integration of services that could be offered to Cairns CMHS consumers under such an arrangement would be significant. It might be that with such a system some consumers could even be diverted from the criminal justice and corrections system permanently. It costs approximately $65K per year to house a residential prisoner. The cost of 0.5 of a psychiatrist's position would soon be saved.

Recommendation 3 – Review of funding for Cairns forensic psychiatrist

I recommend that Queensland Health review the funding it proposes to allocate to the new position of forensic psychiatrist Cairns with a view to increasing it to 1 FTE.

I close this inquest.

Michael Barnes
State Coroner
Cairns
29 November 2007