QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of SVE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/1180
DELIVERED ON:	24 May 2021
DELIVERED AT:	BRISBANE
HEARING DATE(s):	13 May 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, suicide, death in custody, remand prisoner, risk assessment, hanging points.

REPRESENTATION:

Counsel Assisting:	Mr Matthew Hickey
Queensland Corrective Services:	Ms Jesika Franco, Crown Law, instructed by Ms Megan Lincez (QCS)
GEO Group Australia:	Ms April Freeman, instructed by Mr Doug Johnson (Ashurst)

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Introduction

1. SVE[1] was aged 43 years when he was found deceased at the Arthur Gorrie Correctional Centre (AGCC) on 16 March 2019. The cause of death was determined to be hanging.

2. SVE was arrested on 25 November 2018 for 17 very serious sexual offences involving children. On 28 November 2018 he was transported to AGCC on remand. This was his first time in custody.

3. SVE reported that he feared for his safety because of his offences. He was remorseful for his offending and told correctional officers that he was a 'bad person'. He thought other prisoners knew of the charges he faced and wanted to harm him. He told his sons that he was struggling in prison.

4. SVE was granted protection status and was managed under a 'protection' Intensive Management Plan (IMP) in AGCC's Unit B2. On 15 February 2019, he was moved into a single cell.

5. On the day of his death, SVE was upset while speaking with his sons on the telephone. He had also expressed concern about the fact that a prisoner he alleged had assaulted him was working in his unit.

6. In addition to the findings required by s 45 of the *Coroners Act 2003*, these findings consider:

   - Whether SVE should have been subject to a risk assessment process and increased observations while on remand; and
   - The presence of hanging points at Arthur Gorrie Correctional Centre.

The investigation

7. An investigation into the circumstances leading to SVE's death was conducted by Detective Senior Constable Tongiatama from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). His report was submitted to my office and tendered at the inquest.

8. After being notified of the death CSIU officers attended AGCC together with a scenes of crime officer. A crime scene had been established by QCS officers in SVE's cell. Other prisoners were already locked down in their cells. A search of the cell revealed no suspicious circumstances. A fingerprint examination confirmed SVE's identity.

9. CSIU detectives later arranged the seizure of all prison and medical records relating to SVE. They conducted interviews with other prisoners in Unit B2 at AGCC. Statements were also obtained from corrective services staff at AGCC.

[1] These findings have been anonymised following a non-publication order under s 41 of *Coroners Act 2003*.

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

11. A parallel investigation was conducted by investigators appointed by the QCS Chief Inspector. Those investigators prepared a report which was tendered at the inquest. I found this to be a thorough investigation and the report included several conclusions and recommendations that are considered later in these findings.

The inquest

12. An inquest was held at Brisbane on 13 May 2021. All the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

13. Leave to appear was granted to Queensland Corrective Services (QCS) and the GEO Group Australia Pty Ltd, the operators of AGCC at the time of the death. Two staff members from AGCC who worked directly with SVE gave evidence, together with Mr Peter Shaddock, Assistant Commissioner, QCS.

14. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

15. SVE was born in New Zealand. He had two sons in Australia who were in their late teens, and a younger daughter who had moved to New Zealand with her mother. At the time of his death SVE was married and had two step-daughters.

16. SVE had no previous criminal history in Australia or New Zealand, and this was the first time he had been in prison.[2] When SVE was remanded into custody awaiting the hearing of his charges, he asked that he be placed in a protection unit because of the nature of his offences, and this request was granted.[3]

17. During his intake assessment in November 2018 SVE advised medical staff that he was asthmatic and used Ventolin. He said that he usually drank alcohol 2 – 3 times per week and was a smoker but did not take any other drugs. He said he suffered from back and leg pain due to a compression injury at work which occurred about five years earlier.

[2] D2 – pp 163 – 189.
[3] D2 – pp 189 - 190.

18. In his Immediate Risk Needs Assessment (IRNA) interview on 28 November 2018, SVE denied any other medical history including any history of mental illness, suicide attempts and/or suicidal thoughts. He advised the intake Counsellor that he was seeing a psychologist every six weeks, and had last seen them one week before. He did not disclose the reasons for his visits. He was referred to the prison's Health and Psychology Services and advised how to request a review by doctor, and to how to access Prison Mental Health Services.

19. Based on the information given, the Counsellor considered SVE was future oriented, expressing a desire to work and reunite with his family post release. He expected to be incarcerated for 10 years. He was calm, stable accepting of his situation and deemed to be at low risk of harm to himself.[4] A provisional psychologist who assessed SVE on the same day also concluded that he was a very low immediate risk of engaging in suicide or self-harm.

20. SVE was initially housed in Unit B5, which is a protection and special needs unit. On 8 December 2018, he was moved to protection Unit B1.[5]

21. On 9 December 2018, SVE made a phone call to his eldest son. He was sobbing throughout the call to the point that it was difficult to make himself understood. His main concern was that both sons were coping without him.[6]

22. In December 2018, SVE attended the prison medical clinic for a urine test, and it was noted that he had blood in his urine. He advised that he had not had this condition investigated in the past. SVE was referred for an ultrasound and a CT scan, which showed a cyst in his right kidney which did not require further treatment.[7]

23. On 18 January 2019, Counsellor Kendall saw SVE and made the following record of his interaction with SVE:

> *Prisoner presented calm and stable.*
>
> *Prisoner reported being afraid for his safety if the unit inmates found out what he is charged with. Prisoner stated he feels on edge a lot of the time. Counsellor discussed strategies as to how to go about concealing this information. Prisoner discussed his charges and his remorse for the situation he feels he has caused.*
>
> *Prisoner spoke of the impact this has had with his sons. Supportive counselling was provided. Prisoner stated he would like to continue counselling once released.*

[4] D2 – pp 134 – 144.
[5] D13 - paras 32 and 36.
[6] F2.
[7] D2 – pp 147 and 153 – 157.

Prisoner stated that he had passive thoughts of suicide however stated he would not put his family through that. Prisoner denied any recent or current thoughts and stated his sons are a protective factor.

Prisoner stated he is eating and sleeping well and exercising fairly regularly.[8]

24. On 21 January 2019 SVE's charges were mentioned in the Brisbane Magistrates Court and adjourned for further mention on 23 March 2019. SVE's appearance at this mention was not required.[9]

25. On 23 January 2019, SVE alleged he was assaulted by another prisoner. He said that he was punched on the right side of his jaw. He declined to make a formal complaint to Police following this incident. SVE was assessed by a nurse after he told a correctional officer he had been assaulted. SVE told the nurse that he had been hit once in the jaw, and felt some muscle soreness as a result. He declined an ice-pack and was to notify the medical centre if he experienced any other symptoms.[10] The following day SVE was transferred to Unit B2 where he remained until his death.[11] This decision was consistent with the COPD on admission and assessments as he was not identified as a prisoner required to be held in a new stock cell as a prisoner with a self-harm history.

26. On 31 January 2019, SVE again saw Counsellor Kendall. He was observed to be presenting as calm and stable. However, he was extremely worried about his safety and said that he had been threatened in his current unit. Although a supervisor had suggested that he move to a special needs unit, SVE told the counsellor that he felt his current unit was the best place for him and did not want to move. He said that he was able to spend the day in his cell self-isolating. Counsellor Kendall spoke with unit officers afterwards to ensure they were aware of SVE's safety concerns.

27. On 14 February 2019 SVE asked to be placed on a 'protection' Intensive Management Plan (IMP), which required that he be escorted whenever he was outside his unit. He was moved into a single cell, and on 15 February 2019 he signed the IMP acknowledgement agreeing to participate in the plan. The plan set out the following expectations:

    - SVE was to be escorted if he was moved outside his unit;
    - Staff were to record case notes as soon as practicable and on the same day an event relating to IMP intervention occurred;
    - Staff interacting with him were to reinforce behaviour expectations and encourage him to take part in activities;
    - Staff were to encourage SVE 'to verbalise any perceived barriers and seek appropriate assistance where required';

[8] D13 - Annexure 11
[9] D2 - pp 175 - 176.
[10] D13 - Annexure 13.
[11] D13 - para 51.

- The IMP was 'to be reviewed by a multi-disciplinary team, with regular feedback provided to the General Manager;
- There was to be contact with Psychological Services as required;
- SVE's interactions with other prisoners during his out of cell access were not restricted; and
- The plan was to reviewed weekly at the SAFE meeting.[12]

Events leading to the death

28. On 2 March 2019, SVE completed a prisoner request form asking to see a psychologist in respect of his mental health issues. CSO Eichhorn, the unit officer, wrote on the form:

> *Prisoner gets really upset about his charges. Talks to officers and seems anxious (Anxiety?). Thinks everybody in the jail is out to get him.*[13]

29. CSO Eichhorn told the inquest that when a prisoner request form was lodged prisoners were interviewed to obtain more specific information in relation to the request. He said that while SVE was anxious and fearful, he had expressed no thoughts of self-harm at that time.

30. CSO Eichhorn said that if SVE was having thoughts of self-harm, he would have raised a notice of concern. He would also keep SVE line of sight in the Unit B2 interview room, or escort him to the medical unit. He said that it was also possible to ring a psychologist to directly to attend the unit to speak to prisoners who were distressed. While he had received some training in suicide awareness and prevention, experience gave him a good sense of whether a person was at risk of self-harm.

31. The usual process was for the prisoner request form to be placed in a folder to be collected by a member of the health and psychology services team. The details of the request would be inserted into a tracking spreadsheet maintained by the team and counsellors and psychologists allocated according to a priority of needs assessment. Unfortunately, for reasons unknown SVE's request was not entered into the spreadsheet and it could not be established whether it had been reviewed prior to his death.[14]

32. Mr Eichhorn's evidence was that it was not uncommon for prisoners to wait 2-4 weeks before being seen by a psychologist. There were up to 100 prisoners on the wait list to see a counsellor or psychologist and would likely have been several weeks before SVE could have been seen based on the information set out in his request form.

[12] D13 - para 63 - 68 and Annexure 21.
[13] D13 - Annexure 19.
[14] D13.3

33. On 13 March 2019 SVE wrote a complaint, known as a 'blue letter', to the Correctional Manager, requesting that any reference to his case and charges be removed from the newspapers in Units B1 and B2 after his matter was mentioned in court on 25 March 2017. He also said that:

> *The rumour mill from B1 is just waiting for some type of confirmation and will ensure that I come to some type of harm in B2. Even within B2 there may be elements that could want to harm me as well. My main problem is with the leader within B1. His name is AL. He has threatened to kill me and is the trolley boy for B1 and has had other people attack me and chase after me, his frequent presence on the walkway and proximity to B2 has caused safety issues for me.*

34. Later that day he wrote a second blue letter, in which he said:

> *In reference to the other blue letter I sent today, I mentioned AL B1 threatened to kill me. That is true but I did not intend to complain about that as I am afraid of reprisals, it was just an FYI.*[15]

35. CSO Eichhorn told the inquest that blue letters were placed in a blue mailbox within the unit and were collected by administrative staff. The General Manager has 28 days to respond to the letter. He was not aware of the content of the blue letters, although staff usually shared security concerns that were identified in those letters.

36. Mr Shaddock said that many blue letters were received in prisons, and correspondence was triaged based on urgency. In the absence of additional concerns that may appear in IOMS from unit staff they would not be given a priority response. He said that his expectation was that clarification would be sought from the unit and from intelligence staff, together with the history of associations. Those steps may take some time. He indicated that this was not an unusual type of letter in the prison context.

37. Mr Shaddock said that there were a range of risk assessment processes on reception to AGCC. The circumstances and challenges facing SVE were not remarkable.

38. On 16 March 2019 at 7:21am SVE made a phone call to his younger son. He asked his son to visit his co-accused to get their Facebook log-in details to protect their privacy and his physical safety, and to come to visit him when he could. He began to get teary during the call and said he just needed to know whether his sons were angry with him. SVE's son said that they were not angry, and that they both loved him. SVE said that he needed their support, loved them very much, and that he was definitely coming home one day.[16]

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[15] D13 - Annexure 32.
[16] F18 – Phone call 16/3/19. 7:21am.

39. At 9:54am on 16 March 2019, all Unit B2 prisoners were locked in the exercise yard, so that a work crew of three prisoners from Unit B1 could paint inside Unit B2. AL was one of the prisoners in the B1 work crew.

40. CSO Deborah Anderson told the inquest that she had been employed at AGCC for over seven years as a casual employee, although she worked around 70 hours each fortnight. She recalled that on the morning of 16 March 2019 a painting crew comprising 3-4 prisoners from Unit B1 had arrived at Unit B2 to do some touch up painting. They were accompanied by one escorting officer. CSO Anderson and CSO Eichhorn were monitoring the situation to ensure there were no interactions between the painters and the prisoners in the exercise yard.

41. CSO Anderson recalled that prisoner AL was a bold and "cheeky" person, but she was not aware of any association issues between SVE and AL. She did not recall any interactions taking place between the two prisoners while the painting took place. She had no recollection of shouting by the painters at B2 prisoners.

42. Ms Anderson said that 3-4 minutes after the work crew left SVE approached her near the laundry and said he had problems with the prisoners on the work crew. He asked for her assurance that they had all left Unit B2. CSO Anderson said that they had.[17] She told the inquest that SVE did not seem frightened at that time.

43. CSO Anderson said that if she had concerns, she would have made a case note in relation to behavioural changes by SVE or any events out of the ordinary. She said that if she was concerned about psychological issues she would email or call psychological services, medical services or speak to a supervisor.

44. CSO Anderson said that she was familiar with the notice of concern process which flowed from prisoners expressing self-harm ideation. She said that she had been given training in identifying distress and was confident that she would identify if it was obvious and would then follow the notice of concern process. She was also familiar with the PMHS referral process although that involved logistical challenges and a delay.

45. CSO Eichhorn told the inquest that he had been working at AGCC for 12 years in 2019 and recalled SVE. He said that Unit B2 was an overflow from Unit B5 and that both were special needs units and included protected prisoners. B5 was a new stock unit containing safer cells and B2 was old stock with exposed bars.

46. CSO Eichhorn recalled that SVE was anxious and scared of the jail environment as a first time prisoner. He was concerned that he would be assaulted by prisoners from other units in AGCC because of the nature of his offences. Consequently, he was placed on an intensive management

[17] D13 - paras 106 – 109.

plan which required that he be accompanied by a CSO when moving throughout the prison.

47. CSO Eichhorn said that SVE was “skittish”. He thought this was a result of the guilt and shame he felt and because of the nature of his offences. CSO Eichhorn said that SVE kept to himself and regularly asked to be locked in his cell. However, this was not unusual behaviour for prisoners in the Unit B2.

48. Like CSO Anderson, CSO Eichhorn did not recall any issues between SVE and AL. He said it was possible that the painting crew from Unit B1 may have “caused dramas”, he was not aware of any association issues. He thought that it was unusual that the painting crew arrived unannounced. He queried with the escorting officer why this had occurred and was told it was a management decision and the painters were only there for some brief touch-up work. Mr Eichhorn was confident that if there had been association issues identified between any of the painting group and SVE access would have been restricted.

49. CSO Eichhorn said that the painters and the B2 prisoners were only a few metres apart while the work took place and it was feasible that they could have conversed. He did not hear any interaction between the 2 groups because he was in the officers station 4-5 m away and behind a Perspex barrier. CSO Anderson stayed on the floor of the unit with the supervisor of the painting crew.

50. Mr Shaddock said that the question of whether it was appropriate for the painting group from Unit B1 to be given access to Unit B2 had to be considered in the context of information that was known at the time. Risk mitigation strategies were put in place such as the presence of escorting officers, physical barriers between the two groups and CCTV coverage.

51. Mr Shaddock agreed that a prisoner’s first entry into custody was a period of heightened concern. How a prisoner managed this time depended on the individual including their age and knowledge of other prisoners in the environment, together with the nature of their offending. He agreed that persons who had committed sexual offences against children were at increased risk when newly admitted.

52. At about 10:21am SVE made another phone call to his eldest son. During this call SVE was crying. He had a conversation with both his sons about how things were going with them. He asked whether they had both been in contact with their younger sister. He told both his sons that he loved them and to tell their sister he loved her too.[18] After the phone call SVE engaged in his usual activities within the unit, and the CSOs on duty did not note anything out of the ordinary in his behaviour.[19] Mr Eichhorn said

[18] F19 – Phone call 16/3/19, 10:21am.
[19] D13 - paras 113 – 115.

that at the end of his shift he said ‘see you tomorrow’ and SVE responded in like terms.

53. Lockup was at about 5:00pm. At about 8:55pm Correctional Services Officers were conducting observation checks in Unit B2. CSO Griffiths looked through the observation window in SVE’s cell door and could not see SVE in the cell. He went to the officer’s station and confirmed that SVE was supposed to be in the cell. When he returned to the cell and looked through the observation window again, he saw SVE against the wall to the right of the door. He knocked on the window but there was no response. CSO Griffiths called a code blue on the radio and told another CSO to get the keys to the cell.[20]

54. Several other CSOs attended the cell to assist. When they entered the cell, they found SVE was hanging by the neck from bars which extended across the top of the cell wall. CSO Griffiths and CSO Griffioen took SVE’s weight and CSO McSorley used a knife to cut the noose. The CSOs moved SVE into the hallway and commenced CPR. Medical staff and Queensland Ambulance Service (QAS) officers arrived and assisted, but they were unable to revive SVE. QAS Officers declared SVE deceased at 9:25pm.[21]

55. Police attended and examined the scene. SVE had detached one sleeve from a prison-issue long-sleeved shirt and used that sleeve as a ligature. He had hung a towel over the bar to which he attached the sleeve to conceal the noose from view from the outside of the cell. No other person had access to his cell after lockdown.[22]

56. A number of letters to family were found in SVE’s cell, including long letters to his sons advising them on how they should live their lives, and telling them how he was trying to organise his affairs, for instance writing to the bank about his accounts, sending a will to his lawyer, and trying to arrange to declare bankruptcy. He discussed these topics in telephone conversations with his sons as well. In addition, in letters to his mother and phone calls to his sons, he asked them to get a message to his co-accused to tell them not to speak to anyone about the nature of their offences as information could be passed between prisons and could pose a danger to him.[23]

[20] D13 – Attachment 35(c).
[21] A5.1 – para 2.9.
[22] A5.1 – para 2.15 – 2.17 and E1 – Scene photographs.
[23] D5 – D12 and F2 – F19.

Autopsy results

57. On 18 March 2019 Dr Rohan Samarasinghe conducted an autopsy consisting of an external examination and CT scans of the body.

58. Dr Samarasinghe found that the ligature mark on the body was consistent with the material used for the noose, and that there were petechiae (broken blood vessels) in the eyes that were consistent with asphyxiation.

59. The toxicology results did not show any drugs or alcohol in the deceased's system.

60. Dr Samarasinghe concluded that the cause of death was hanging.

Investigation findings

61. A report dated 30 September 2019 detailing the investigation and findings was provided to the State Coroner. DSC Tongiatama's conclusions were given in his report as follows:

> *Investigations…indicate the death of SVE was non-suspicious. Nothing discovered during the complete investigation has caused a change to the preliminary assessment.*
>
> *Investigations did not reveal issues with any other prisoners in the deceased's unit or the prison that would put the deceased's life under immediate threat. The deceased's cell indicates he was the only one in his cell at the time and prior to his death. No defensive wounds were located on the deceased during the Autopsy.*
>
> *There appear no clear signs SVE was going to take his life, however after speaking with prisoners from the unit and reviewing PTS calls made by the deceased he was in a very distressed and upset state of mind. The deceased received adequate treatment for both his physical and mental health by Corrections.*
>
> *As there are no signs of forced entry to the deceased cell and no evidence to raise any suspicions it appears the deceased has taken his own life by fashioning a noose out of prisoner issued clothing attached the noose around his neck and tied the other end to a metal horizontal bar to the right of his cell door, causing his death by hanging.*[24]

[24] A5.1 - p 8.

OFFICE OF THE CHIEF INSPECTOR REPORT

62. In March 2020, the Office of the Chief Inspector (OCI), Queensland Corrective Services (QCS), provided an incident investigation report into SVE's death to the court. The OCI "has a mandate to provide impartial assessment of the Queensland corrections system to the Commissioner, QCS".[25]

63. The OCI investigators made the following findings and recommendations in the report:

- SVE died at or around 9.25pm on 16 March 2019 in AGCC Unit B2 as a result of hanging. No suspicious circumstances have been identified.

- While it is evident SVE was frightened for his safety in prison due to the type of offences he had committed, he was appropriately managed on a Protection IMP. There is no evidence that he felt threatened or was concerned about his safety in his own unit.[26]

- SVE expressed remorse and regret about the offences he was alleged to have committed. He said to officers on more than one occasion that he was a bad person. He also said that he missed his family, in particular his teenage sons. He was able to maintain contact with them by telephone and mail.

- On 2 March 2019, SVE completed a request form to see a psychologist about his mental health issues. The request was not acted on before his death. There is no evidence that he was identified as being at risk of self-harm when the form was completed and before his death.

- On the morning of 16 March 2019, SVE became upset while speaking with his sons, but no officers observed this. After the call, he told Prisoner Mohammad that he was missing his family. There is no evidence that he spoke to officers about this or sought out additional support.

- SVE feared encountering AL, who was painting in Unit B2 on the morning of 16 March 2019, but there is no evidence of any interaction between them on that day. There was a physical barrier between SVE and AL, who was supervised while he was in Unit B2. An officer reassured SVE.

- In the days before SVE's death, correctional staff did not observe him expressing any feelings or displaying any behaviour that indicated he intended to self-harm. It appears that at no time during his incarceration did any prisoners raise concerns about him being at risk.

[25] D13 - para 4.
[26] This finding is inconsistent with the blue letters.

- It is unclear when SVE decided to take his own life and whether any specific trigger caused him to take his own life. It is possible that a combination of several factors including his impending court date, a looming long prison sentence, his concern for his safety and missing his family all contributed to his decision.

64. While the OCI report found that there were appropriate policies, procedures and practices in place for the proper assessment and continuing management of SVE, it also made the following findings in what are described as two key matters:

    1. *[The 2 March 2019 request to see a psychologist] was not actioned. When he died, psychological services had the form, but it had not been entered into a tracking spreadsheet and had not been reviewed.*

       If the form had been reviewed on or around 3 March 2019, it might have prompted the team of psychologists to seek out further information to make a decision about prioritising his request.

       The process for handling completed request forms is not secure. The forms are either placed in an in-tray in the officers' mess or handed to the airlock officer as officers leave the centre. Psychologists then either collect the forms, or are provided them by whoever they were handed to.

    2. *[SVE sent a Blue Letter on 13 March 2019] which was date stamped as being received but was not acted on before his death. In the letter, he referred to being assaulted and raised association issues.*

       The prisoner SVE referred to in his letter was in another unit, but he claimed that the prisoner arranged for other people to attack and chase him. If the letter had been acted on, his allegations of assault and concerns would have been investigated, and an association issue flagged in the intelligence section of IOMS. This might have led to AL not being tasked to the paint crew that carried out painting work in Unit B2 on the day of SVE's death.[27]

65. The OCI report noted that while COPDs and Local Instructions were not entirely complied with, this did not cause SVE's death. There was also no evidence that SVE was inducted when he arrived at AGCC or that he was given the AGCC Induction Booklet. SVE's first unit induction occurred seven days after he was transferred to Unit B5.

66. The reason SVE's safety order was rescinded is not recorded. There is no indication that it was rescinded inappropriately. SVE signed his IMP, which was being enforced, but there is no record in IOMS of him being placed on an IMP and being provided with a copy of his IMP.

[27] D13 – paras 217 – 214.

67. Daily case notes were not completed in IOMS while SVE was on an IMP and several days were missed.

68. Given these circumstances, the OCI report noted that:

> *It is possible that SVE not having access to the induction process and not being provided the induction booklet contributed to his anxiety. However, his death occurred some months after his arrival at AGCC and it seems unlikely to be causally linked to his death. This is because he had the opportunity to seek out information and guidance from officers and/or fellow prisoners and had access to information in his unit. This is evidenced by his request to go on an IMP and to complete the referral form to see a psychologist/counsellor.*[28]

69. Having regard to these findings the OCI report made the following recommendations:

> *Recommendation 1*
> *The Chief Superintendent, AGCC, ensures that prisoner request systems are reviewed to ensure that request forms completed by prisoners are collected daily, are appropriately prioritised and escalated, and that adequate resources are available to respond to prisoners' requests*
>
> *Recommendation 2*
> *The Chief Superintendent, AGCC, implement an oversight and assurance process to ensure that prisoners receive an adequate induction when they first arrive at AGCC.*[29]

70. Finally, the OCI report concluded there is no evidence that SVE intended to self-harm before the day of his death. He was clearly under stress but did not display any concerning behaviour or verbalise any intention of self-harm to officers or other prisoners in the days leading up to his death.[30] The investigators also found that the staff response to the discovery of SVE's body was appropriate and sufficient.

Hanging Points at AGCC

71. The OCI Report did not consider or make any recommendations about the availability of hanging points in cells at AGCC such as that in which SVE was able to hang himself, apart from noting that:

> *AGCC is made up of older units, often referred to as 'old stock', and new units, or 'new stock'. The new stock has 'safer design' cells. At the time of his death, SVE was housed in Unit B2, part of the old stock.*[31]

[28] D13 – para 228.
[29] D13 – pp37 – 38.
[30] D13 - pp 39 – 42.
[31] D13 - para 17.

72. The safer cells in the new stock units at AGCC focus on removing and reducing access to ligature points within the cell. This requires enclosure of window openings within the cells to prevent prisoners from accessing security bars, and the installation of anti-hanging tap wear, shower and light fittings, anti-hanging joinery items and flush mounted wall fixtures.[32]

73. In 2011 and 2012 State Coroner Barnes recommended, following inquests into three hanging deaths at AGCC, that the State of Queensland should investigate eliminating the presence of hanging points in prison cells. Since that time QCS has increased the number of safer cells in correctional Centres across Queensland.

74. The Queensland Government's most recent response to that recommendation was provided in October 2015.[33] At that time it was noted that 650 cells throughout the State were still waiting to be modified with 138 cells at Townsville Correctional Centre, 268 cells at AGCC and 244 at Borallon Training and Correctional Centre. The response also noted that QCS continues to increase the number of safer cells in Queensland correctional facilities using a three phased approach.

    - First, QCS ensured that a limited number of 'safer' prisoner cells were established within each correctional centre. These were then available to house those prisoners individually identified as being at-risk of suicide/self-harm.
    - Second, as capital funds become available, cells are modified either as a separate project or as part of a site-wide redevelopment project to safer cell specifications.
    - Finally, all new cells constructed since 1996 are designed to minimise self-harm and safer cell designs have been refined since that time. Safer cells are available in secure cell accommodation at every correctional centre within the state.

75. Mr Shaddock's evidence was that there are now a total 340 old stock cells across Queensland prisons. There are still 268 cells awaiting modification at AGCC and 72 at the Harold Gregg Unit at Townsville Correctional Centre. Mr Shaddock said that the implementation of safer cells had to be considered in the context of competing budgetary priorities for QCS and the fact that prisons are operating well above capacity. The refurbishment of the cells at AGCC would cost $150M, including the construction of temporary cells to house prisoners already at that centre.

76. Mr Shaddock said that the current budgetary priorities included stage 2 of the Southern Queensland Correctional Centre, the refurbishment of the Capricornia Correctional Centre, the installation of 1004 bunk beds across the system, and upgrades to the Harold Gregg Unit at Townsville – which was older stock than AGCC.

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[32] B8 – para 54-56

[33] https://www.justice.qld.gov.au/__data/assets/pdf_file/0010/452845/qgr-cartledge-a-20160114.pdf

77. Mr Shaddock was not able to predict when the Queensland Government might allocate the funds required to upgrade the 268 cells at AGCC. He considered that the lack of upgrades to old stock cells at AGCC was defensible in the context of competing priorities for QCS.

78. Mr Shaddock also said as part of operational enhancements following the resumption of QCS control of AGCC, an additional 200 staff had been allocated to AGCC. Those were predominantly CSOs but also included psychologists, cultural liaison officers and administrative staff.

Expert Report

79. The Coroners Court engaged an expert in suicide research and prevention, Dr Samara McPhedran, to provide a report[34] in relation to:

- Whether the existing AGCC policies and procedures in respect of mental health referrals and appointments were adequate and appropriate;
- Whether there was any feature of Mr SVE's circumstances which should have resulted in a different response in terms of mental health treatment;
- Whether staff responses to Mr SVE during his admission at the AGCC were appropriate; and
- Any other issues regarding Mr SVE's circumstances/care.

80. Dr McPhedran concluded that there was no evidence to indicate that SVE displayed any intent to die by suicide before his death. There were no apparent indicators of missed opportunities for intervention that could reasonably be seen to have changed the outcome.

81. Dr McPhedran's report indicated that while the relevant policies and procedures were generally appropriate, the procedures for requesting a visit from a psychologist did not facilitate a timely response. However, when other circumstances are considered, it is unclear whether SVE having contact with a psychologist would have changed the outcome.

82. Dr McPhedran noted that SVE found prison life to be difficult and was fearful that the nature of his charges would become known to other prisoners and lead to him being physically harmed. However, the records did not appear to indicate that he made any verbal or written disclosures, or displayed behaviours or other non-verbal signs, that were indicative of imminent suicide risk or suggested that he needed any other responses than the ones he received.

83. SVE had expressed 'passive' suicidal ideation, not accompanied by a wish to die. Dr McPhedran noted that screening and assessment processes

[34] Ex A7

typically focus on active ideation as well as the presence of suicidal intent and plans in identifying the presence of risk and protective factors. She noted that the relevance of passive ideation as an indicator of suicide risk has not been well established.

84. Dr McPhedran considered that while there may be future benefit to QCS documents explicitly identifying the importance asking further questions in the event individual discloses passive ideation, the absence of explicit procedural directives did not play a role in assessing SVE's suicide risk. It was clear that SVE was queried about suicidality and denied having any active thoughts, plans, or intent, and indicated that he had protective factors (such as his relationship with his sons).

85. Dr McPhedran said that while suicide often occurs after a 'precipitating event' (such as an episode of interpersonal conflict), it is unclear whether seeing the Unit B1 prisoners played a role in SVE's suicide later that day. She indicated that although there was temporal relationship between the two events, the available materials do not allow for such conclusions to be drawn.

Findings required by s. 45

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

Identity of the deceased – SVE

How he died – SVE had been remanded in custody at Arthur Gorrie Correctional Centre for serious sexual offences against children. He was aware that he faced a lengthy term of imprisonment. He was anxious about being identified in prison as a child sex offender. After he was assaulted in Unit B1 his fears for his safety escalated.

SVE intentionally hanged himself using a piece of fabric tied to exposed bars in his cell while incarcerated at Arthur Gorrie Correctional Centre.

Place of death – Arthur Gorrie Correctional Centre, Wacol Queensland, 4076 AUSTRALIA

Date of death– 16 March 2019

Cause of death – Hanging

Conclusions

87. I adopt the conclusions reached in the OCI Report. I agree that there was no evidence that SVE intended to self-harm before the day of his death. While he was distressed, he did not display any concerning behaviour or express any intent to of self-harm in the days leading up to his death. There were no suspicious circumstances surrounding the death.

88. The fact SVE identified that he was seeing a psychologist when he was received into prison should have prompted a referral to the Prison Mental Health Service. The OCI report also suggested that if the Prisoner Request Form from SVE had been reviewed around 3 March 2019, psychologists might have prioritised his request.

89. However, it was clear from the evidence that those steps would unlikely have made any difference to the outcome. The specific nature of his mental health concerns had not been identified and there were over 100 prisoners waiting to be seen by a psychologist. CSOs Anderson and Eichhorn said that if the circumstances required an acceleration of the timing for SVE to see a psychologist, they could have asked the psychologists to attend the unit or raised a notice of concern.

90. While there is evidence that SVE was assaulted on one occasion, he was moved in response to that assault. AGCC also responded to his concerns for his safety by placing him on an IMP. There is no evidence that he was housed with violent offenders after he was moved to Unit B2, or that there were any further attacks upon him.

91. While child sexual offenders may be targeted by other offenders in prison there was no evidence that SVE was accommodated other than in a special needs unit at AGCC, having regard to his specific circumstances and the nature of the charges he was facing.

92. It was also not clear that SVE was fearful within Unit B2 until he sent the blue letters on 13 March 2019, but he did not directly communicate those concerns to the officers within that unit.

93. With respect to the concern about the delay in actioning the blue letters at the time of SVE's death, I accept Assistant Commissioner Shaddock's evidence that the relevant policies and procedures are sufficient to deal with processing of such letters. I also accept that the identification of a concern about association with another prisoner does not mean there will be no contact between the identified prisoners at any time, particularly if risks are appropriately managed.

94. I also adopt the conclusions contained in the Dr McPhedran's report that:

- There was no evidence that SVE displayed any intent to die by suicide;
- There were no missed opportunities for intervention that would have changed the outcome;
- Relevant policies and procedures were generally appropriate;
- Contact with a psychologist would not necessarily have changed the outcome;
- While SVE was fearful, this should not be taken to indicate the presence of an underlying psychological condition that may have elevated his risk of suicide.

Comments and recommendations

95. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, 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.

96. Having regard to the recommendations made by the investigators engaged by the Office of the Chief Inspector and the response to those, I make no further recommendations about those matters.

97. Mr Shaddock identified that it is not yet known when the Government will be able to implement its commitment to the refurbishment of the remaining 268 cells at AGCC that do not have safer cell specifications in place.

98. I acknowledge that in this instance AGCC applied appropriate risk management processes in identifying SVE's risk of suicide. However, as those processes cannot predict every attempt at suicide the removal of access to a ready means of suicide should continue to feature in suicide prevention strategies.

99. While I accept that Government budgets are limited and the refurbishment of cells with hanging points is an expensive process, it is now 30 years since the Royal Commission into Aboriginal Deaths in Custody recommended that hanging points in prisons and police cells be screened. That recommendation has been accepted by successive governments. There have been numerous coronial recommendations relating to the removal of hanging points over that time.

100. The Australian Institute of Criminology has reported that 64.5% of the 956 deaths in custody in Australian between 1980 and 2019 not related to natural causes were the result of hanging.[35] However, the AIC also noted that the rate of hanging deaths remained stable in 2018-19 (0.03 per 100 prisoners). This represents an 86% decrease since the rate of hanging deaths reached its peak in 1983– 84.

[35] Deaths in Custody Australia, 2018-19, Table D13: Deaths in prison custody by cause of death, 1979–80 to 2018–19. The total number of deaths was 1880.

101. QCS submitted that as the previous coronial recommendations are already under ongoing consideration there was no need for a further recommendation in relation to hanging points. However, noting that it is over five years since the 2015 Government response to 2011-12 coronial recommendations for the removal of hanging points in Queensland correctional centres was published, I make the following recommendation.

Recommendation

I recommend that the Queensland government publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy.

102. I close the inquest.

Terry Ryan
State Coroner
BRISBANE