QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jayde Stephen Donovan BIDDULPH**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2009/3151
DELIVERED ON:	13 November 2012
DELIVERED AT:	Rockhampton
HEARING DATE(s):	10 October 2012; 12 November 2012
FINDINGS OF:	Mr Michael Barnes State Coroner
CATCHWORDS:	CORONERS: Death in custody, assessment of risk of prisoner to prisoner violence

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Kay Philipson

Table of Contents

The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Jayde Stephen Donovan Biddulph. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

In July 2009, Jayde Biddulph commenced a relationship with the former partner of his friend Ryan Dwyer who had recently been imprisoned at the Capricornia Correctional Centre (CCC). When Mr Dwyer became aware of the relationship he threatened to assault Mr Biddulph, a threat that took on new significance when Mr Biddulph was also imprisoned at the CCC in November 2009.

On the morning of 16 December 2009 the two men came face to face for the first time since their imprisonment. A short but brutal fight broke out and seconds later Mr Biddulph lay on the ground, unconscious and bleeding. He died a short time later.

These findings:

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

- determine whether the authorities charged with providing for the prisoner's protection adequately discharged that responsibility; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

An investigation of the death of Mr Biddulph was conducted by Detective Sergeant Lori Hicks from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). In her absence, Detective Hicks' supervising officer, Detective Senior Sergeant (DSS) Rosemary Walker gave oral evidence at the inquest relating to the extent and findings of the investigation.

Soon after the incident, the scene of the assault was sealed off and monitored by Queensland Corrective Services (QCS) staff until the arrival of officers from the Rockhampton Criminal Investigation Branch (CIB). Scenes of crime officers attended the CCC and conducted a forensic examination and a detailed set of photographs were taken. Mr Dwyer was taken to the detention unit where his clothes were removed and bagged and his injuries later photographed.

Detectives from the CSIU were advised and travelled from Brisbane at the earliest opportunity. On arrival they inspected the scene and, after being briefed on the alleged events, conducted an interview with Mr Dwyer. Interviews were then conducted with a large number of witnesses, including those who had seen the assault and inmates and CCC staff who had been in contact with Mr Dwyer or Mr Biddulph in the weeks prior. The former partner of the two men was interviewed and provided police with a series of letters from Mr Dwyer containing threats against Mr Biddulph.

All records from CCC relating to the two prisoners were seized; the information management system at the prison was interrogated and detailed statements taken from staff involved in the process of allocating accommodation to Mr Biddulph. Medical records were inspected in relation to the appointments that both prisoners were on their way to attend when the fight occurred. The tapes of telephone conversations made by the two men from the CCC were seized.

The material collated by the investigating officer was exhaustive, as one would expect for a matter the subject of a Supreme Court murder trial. When complaints were received from two prisoners about the conduct of various corrections officers at the CCC in connection with the incident, they were investigated thoroughly. The nature of these complaints and the outcome of the resulting adjunct investigation are set out below.

An investigation ordered by the Chief Inspector QCS ran concurrently with the QPS investigation. It resulted in a report that was tendered at the inquest and which focussed on the adequacy of policies and procedures at the CCC. I have set out the conclusions and recommendations of this report later in these findings.

I am satisfied the investigation was thoroughly and professionally conducted and all relevant material was accessed. I thank all those involved.

Criminal proceedings

On 17 December 2009 Ryan Dwyer was charged with the murder of Jayde Biddulph. He was tried between 1 and 4 August 2011 in the Supreme Court at Rockhampton. The jury found him not guilty of murder but guilty of manslaughter.

On 22 November 2011 he was sentenced to nine years imprisonment for that offence.

The Inquest

A pre-inquest conference was held in Brisbane on 10 October 2012. Mr Johns was appointed counsel assisting and leave to appear was granted to Queensland Corrective Services. The inquest was held in Rockhampton on 12 November 2012. All of the statements, records of interview, medical

records, photographs and materials gathered during the investigation were tendered at the inquest.

In addition to DSS Walker, four other witnesses gave oral evidence. A total of 224 exhibits were tendered. I am satisfied all information relevant to and necessary for my findings was made available at the inquest.

The evidence

Personal circumstances and background to the assault

Jayde Stephen Donovan Biddulph was born at Murwillumbah on 21 August 1979 to Stephen Knight and Dianne Biddulph. In his early teens he met and became friends with Ryan Dwyer. Some years later, while living near Toolooa they were part of a group that included Darlene McClure. She would go on to form a long term relationship with Mr Dwyer and they had a child. In 2005, Mr Biddulph also had a child, Aaliyah.

Both men had numerous convictions for various property and drug offences. In June 2009 Mr Dwyer was charged with a number of break and enter offences. He had been on parole since February 2008 after serving 14 months of a four year prison sentence. His parole was not due to expire until February 2011. The further offences resulted in a suspension of parole and he was returned to CCC on 16 June 2009 to serve the remainder of his initial sentence.

Mr Dwyer's relationship with Ms McClure had been volatile for an extended period and, it appears, did not survive the revocation of Mr Dwyer's parole although they maintained regular contact.

In late June or early July 2009, Mr Biddulph moved in with Ms McClure and another man who, a short time later, was also imprisoned at the CCC. He told Mr Dwyer of the relationship that by then had developed between Ms McClure and Mr Biddulph.

On 13 July 2009, Mr Dwyer wrote to Ms McClure and referred to her relationship with Mr Biddulph. Although the focus of that letter is on maintaining contact with his daughter, another letter sent the following day is more aggressive in tone and contains threats to assault Mr Biddulph. In a series of letters and phone calls continuing until December 2009, Mr Dwyer continued his threats to assault, and even to kill, Mr Biddulph. One letter Ms McClure handed to police is dated 13 September 2009 and addressed directly to Mr Biddulph. In it Mr Dwyer threatens to assault Mr Biddulph when he next confronts him.

In his interview with police on 16 December 2009 Mr Dwyer stated that in June that year Mr Biddulph had promised to 'look after' Ms McClure while he was imprisoned. Mr Dwyer clearly felt betrayed by the fact a relationship then developed. The letters make it clear it caused him significant emotional distress.

Mr Biddulph had a criminal history dating back to early adulthood. When he was sentenced to six months imprisonment for various stealing and break and enter offences in the Gladstone Magistrates Court on 19 November 2009, it was to be his third period of incarceration.

When Mr Dwyer found out about Mr Biddulph's impending arrival he told Ms McClure 'it would be on' when he saw Mr Biddulph.

Ms McClure told police she had not considered disclosing these threats to police. When Mr Biddulph was imprisoned the threats continued. She knew Mr Biddulph was aware of the threats and it would not have been unreasonable for her to assume he could inform staff at the CCC himself of any concerns he had for his safety.

Biddulph arrives at the CCC

Mr Biddulph arrived at the CCC on 24 November 2009. He underwent an Initial Risk and Needs Assessment (IRNA) that included a set of prescribed questions. None of those questions related to fears the prisoner may have had about other inmates. The counsellor who conducted the IRNA accordingly did not elicit any information relating to Mr Dwyer or Ms McClure.

During the IRNA Mr Biddulph did, however, lodge a request to be placed in protection. That set in process a referral to a senior advisor in Offender Management, Ms Patricia Misztal, who was tasked with interviewing Mr Biddulph and completing an administrative form: *Application for Placement Assessment*.

Ms Misztal told the inquest it was her practice to create a handwritten application form while interviewing the prisoner, which the prisoner signed and which became part of his file. She would then enter the details taken on that form into an electronic version contained on the QCS Information and Offender Management System (IOMS). This electronic form would be sent to the General Manager for a decision on the application.

The handwritten and electronic versions of the application were both tendered at the inquest. In the handwritten version Ms Misztal recorded the following in the section 'Reasons for Request':

- *Previous Protection placement*
- *Close friend of C Crawford (not currently in centre)*
- *Currently seeing Ryan Dwyer's ex-girlfriend*

She told investigators and stated again at the inquest that the primary basis for Mr Biddulph seeking placement as a protection prisoner was his association with Mr Crawford who had apparently been the subject of a violent attack by a group of Indigenous prisoners. In her interview with investigators appointed by the QCS Chief Inspector, Ms Misztal said that although Mr Biddulph had raised the matter of Ryan Dwyer he also said he 'had no issues with this'. In her statement to police she stated:

> *I recall asking Biddulph if this was going to be a problem to which he replied words to the effect 'No, it's all good'.*

Ms Misztal told the investigators she did not consider the disclosure by Mr Biddulph to be particularly remarkable; and as he had not disclosed any threat against him by Mr Dwyer she did not consider it necessary to pass the information on to the General Manager. She told the inquest that when Mr Biddulph told her 'No, it's all good' she did not consider it needed to form part of the 'reasons for application' in the application submitted to the General Manager. She maintained this position notwithstanding the prisoner was asked to sign the written document, presumably confirming the basis for their request.

She repeated this at the inquest. I have doubts as to whether this is an accurate account of what Mr Biddulph said. Not only was it unlikely to have been his state of mind in view of the on-going stream of threats issuing from Mr Dwyer, it is inconsistent with Ms Misztal recording his involvement with Mr Dwyer's ex-girlfriend as a reason for seeking protection. Indeed on her account there was no reason for the subject to even be raised. Ms Misztal's attempts to explain this incongruity at the inquest were not persuasive.

In any event when Ms Misztal created the electronic application form she did not include any reference to Mr Biddulph's relationship with Mr Dwyer's ex-girlfriend when citing the reasons for request. It referred only to Mr Biddulph's association with Mr Crawford and the fact he had previously been a protection prisoner. This proved sufficient and the application was approved.

In accordance with the procedure in place at the CCC, Mr Biddulph was processed as a protection prisoner while his application was being considered. Ms Misztal told the inquest it was her practice to contact the supervisor in charge of the secure section of the prison where protection prisoners were housed, by telephone to notify that person of the reason the prisoner was being sent to that section. At the inquest she stated she had done this and has no doubt she would have told the Secure Supervisor of the conversation she had with Mr Biddulph relating to Mr Dwyer.

The Secure Supervisor on 24 November was Selwyn Toby. He gave evidence at the inquest and stated that in his experience telephone calls from Ms Misztal or one of her colleagues were regularly, but not always, made for new prisoners. He did not remember such a call in relation to Mr Biddulph but accepted it could have been made. He did not remember any reference to Mr Biddulph's relationship with the ex-girlfriend of Mr Dwyer or any other reference to a problem between those two inmates. He was confident had the conversation between Mr Biddulph and Ms Misztal been passed on to him he would have taken further steps to notify his immediate superior and to make further enquiries with both men. It is also likely had he been told of this possible source of conflict, he would have remembered it when the fatal fight occurred three weeks later.

Mr Biddulph was interviewed by Mr Toby later on 24 November 2009. The purpose of this interview, in part, was to assist in determining an appropriate unit and cell placement. When he interviewed Mr Biddulph, Mr Toby did not have access to the handwritten *Application for Placement Assessment*. Further, although he had access to IOMS, he told investigators the interview and placement, in practice, always occurs before the electronic version of this form is entered by the officer from Offender Management.

It was Mr Toby's practice during this initial interview to always ask whether the prisoner had any concerns about other inmates. He told investigators for the QCS Chief Inspector, and again stated at the inquest, that during his initial interview with Mr Biddulph nothing was mentioned about Mr Dwyer. During an interview with police, though, Mr Toby did refer to a vague recollection of there being some discussion about Mr Biddulph seeing Mr Dwyer's ex-girlfriend during this interview but Mr Biddulph did not appear too concerned. These interviews are not recorded and a review of Mr Toby's diary at the time failed to reveal any notes relating to Mr Biddulph.

Mr Toby later stated he was likely mistaken when he said this to police. If he had known about the connection he considers it likely he would not have placed Mr Biddulph in unit S1. This unit is connected by a walkway with units S2 – S4. Mr Dwyer was housed in unit S4. An appropriate and available alternative would have been to place Mr Biddulph in unit S9 or S10 thus limiting the prospect of any contact between the two.

Events leading to the assault

In September 2009 Mr Dwyer was briefly hospitalised at which time he was guarded by a custodial corrections officer (CCO) Ross Griffin. At that time he spoke to Mr Griffin about the circumstances of Mr Biddulph forming a relationship with his former partner. It was clear to CCO Griffin that Mr Dwyer was *pissed off* about it but he does not recall any threats being made against Mr Biddulph. At that time Mr Biddulph was not in custody and CCO Griffin did not consider any action needed to be taken.

At another, unspecified time Mr Dwyer says he spoke to a number of corrections officers about the relationship. He claims to have been concerned about being *breached* if a fight was to ensue although he could not say whether Mr Biddulph was even in custody at this point. His evidence in this regard lacked particularity and I do not consider I can rely upon any aspect of it. On his own account he told the officers he did not want to fight and would walk away if confronted.

After Mr Biddulph was imprisoned in November he contacted Ms McClure to tell her he had been housed in a different unit to Mr Dwyer. Ms McClure also continued telephone contact with Mr Dwyer and recalled him telling her if the two met in prison *it would be on*. The placement of Mr Biddulph in a separate unit from Mr Dwyer managed to prevent contact between the two until the morning of 16 December 2009.

On 21 October 2009, well prior to Mr Biddulph's imprisonment, an appointment was made for Mr Dwyer to see a psychiatrist in the CCC medical centre at 9:00am on 16 December 2009. On 1 December 2009, blood tests results from samples taken during his admission medical assessment revealed Mr Biddulph to have hepatitis B. This prompted regular scheduled injections – one of which was also set for 9:00am on 16 December 2009.

Those prisoners in units S1 to S4 with 9:00am medical appointments were released from their units just prior to that time. The four units are linked by a secure walkway that segregates the prisoners from the general population at the CCC. The practice was for the protection prisoners to congregate in the walkway until they could be escorted to the medical centre without contact with the mainstream prisoners. On 16 December 2009 that had the effect of bringing Jayde Biddulph and Ryan Dwyer into direct contact.

The assault and aftermath

Mr Dwyer said that as he sat talking in the walkway, he heard the doors of another unit open and saw two prisoners emerge onto the walkway, one of whom he recognised as Mr Biddulph. He said Mr Biddulph approached him and it was clear a fight would ensue. Mr Dwyer and Mr Biddulph both *kicked off their thongs* and approached each other. The involvement of both men was consensual to the extent neither sought to avoid the fight. Eye witness accounts indicate Mr Biddulph said words to the effect *Let's get it on* and threw the first punch. If a punch was thrown by Mr Biddulph it had little effect and he was soon overcome by Mr Dwyer and he fell to the ground.

After Mr Biddulph fell to the ground Mr Dwyer continued to punch the head of Mr Biddulph while he was unconscious. He then moved away from Mr Biddulph before anyone else could intervene. It is likely about six punches struck Mr Biddulph in the head and neck.

An officer who saw the fight from inside the fishbowl (the officers' observations station) called a code yellow (prisoners fighting). The first officer on the scene realised Mr Biddulph was seriously injured and called a code blue (medical emergency). This resulted in the prompt attendance of nurses who assessed Mr Biddulph with the use of a defibrillator, moved him to the medical centre and commenced CPR en route. At the same time Mr Dwyer was handcuffed and soon moved to the detention unit. There he was appropriately strip searched and his clothing bagged for further examination.

Records show the Queensland Ambulance Service (QAS) was called at 9:14am and arrived to treat Mr Biddulph at 9:34am. They arrived to find staff conducting CPR and asked them to continue. Extensive resuscitation attempts involving IV administration of adrenaline, saline and sodium bicarbonate failed to revive Mr Biddulph. He was pronounced deceased by a QAS paramedic at 10:20am.

Autopsy results

An external and full internal post-mortem examination was carried out on 17 December 2009 by an experienced forensic pathologist, Dr Nigel Buxton.

Samples were taken for histological and toxicological testing. The latter did not reveal the presence of drugs or alcohol.

Dr Buxton made the following interpretation of his findings:

> *Death in this patient is due to a closed head injury leading to a cerebral oedema. Contusions to the left parietal lobe are seen. Extensive subarachnoid and intraventricular haemorrhage was present with secondary neurogenic pulmonary oedema.*
>
> *There was no evidence of anatomical defects within the Circle of Willis and no evidence of a pre-existing ruptured berry aneurysm. The vertebral arteries were intact where they exited from the spinal column.*
>
> *Extensive bruising to the soft tissue of the face and neck are seen consistent with assault.*
>
> *The injury to the rear right hand side of the neck would suggest at least one blow had come from behind (King hit). This is the most significant injury.*
>
> *There was no evidence that the deceased had delivered a punch.*
>
> *The separation of the bruises - to the back right side of the neck, right side of the face, the central lip on the left side of the nose would suggest several blows had been struck. It is probable that no more than 6 blows have been delivered.*
>
> *There was no evidence that more than two blows were delivered with any great force. The principal blows were to the right side of the face and the right posterior neck.*

Dr Buxton issued a certificate listing the cause of death as:

> *1(a) Traumatic cerebral contusions with subarachnoid and intraventricular haemorrhage*
>
> *due to, or as a consequence of*
>
> *(b) Assault*

Investigation findings

CCTV footage showed the preliminary movements of Mr Dwyer prior to the assault but did not capture the movements of Mr Biddulph or the interaction between the two men.

In the course of searching Mr Dwyer he was found to have a number of white tablets in his possession. Testing showed these to be tablets of his prescribed medication; serequol and tramadol. On his own admission Mr Dwyer had a habit of hoarding his prescribed medication in order to take higher doses at times when he felt he most needed it. On the morning of the assault he had taken more of his medication than prescribed. I do not consider this influenced the course of events.

Findings required by s45

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

Identity of the deceased –	The deceased person was Jayde Stephen Donovan Biddulph.
How he died -	Mr Biddulph died from injuries sustained when he was punched to the head and neck during a fight with another prisoner and then, while laying unconscious on the ground, he was punched several more times to the head by that prisoner. At the time he was in custody at the Capricornia Correctional Centre.
Place of death –	He died at Etna Creek in Queensland.
Date of death –	He died on 16 December 2009.
Cause of death –	Mr Biddulph died from traumatic cerebral contusions with subarachnoid and intraventricular haemorrhage.

Comments and recommendations

Section 46, 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.

There is no doubt the primary and proximate cause of Mr Biddulph's death was the vicious assault of him by Mr Dwyer. That has been appropriately responded to by the criminal justice system. From a prevention perspective however, the circumstances of the case focus consideration on whether the correctional managers should have been more alert to the danger of such an assault occurring and moved to reduce the risk of it.

I am satisfied the meeting between the two men on 16 December 2009 was co-incidental (although increasingly likely to occur as time went on). It is clear the meeting was not orchestrated by any person.

For the reasons detailed earlier, I have doubts as to whether Mr Biddulph told Ms Misztal he had no concerns about Mr Dwyer and I also doubt she passed on the information about the possibility for conflict stemming from the relationship issues to Mr Toby. In any event, Mr Biddulph had ample opportunity to raise his concerns with correctional officers if he wished to. I suspect he believed he could avoid Mr Dwyer as they were housed in different units.

Even had the correctional officers more actively engaged with this aspect of the prisoner's assessment it is by no means clear that anything would have been done differently. I accept such complications are not rare among the prison communities and all involved, including Mr Biddulph may well simply have considered this factor to be just one more of the risks of the correctional environment.

It is impossible to discern what the men may have said if questioned further about their history and current relationship. Although both men had made it clear to each other and Ms McClure that *it would be on* if they saw each other, it is likely both would have been more circumspect when speaking to prison officers.

It is also obvious that on the day of the fatal incident Mr Biddulph could have regained entry to his unit rather than approaching Mr Dwyer if he feared for his safety. I expect neither man for a moment anticipated a 'punch up' would result in the death of one of them.

I am satisfied the report compiled for the Chief Inspector QCS has adequately identified the systemic shortcomings made evident by this case. It is clear that at the time of Mr Biddulph's death there was a system in place at the CCC to protect prisoners who needed to be segregated from other groups and individuals in the prison population. It relied heavily on the discretion of individual officers in terms of when and how information would be passed to those in a position to put in place practical measures such as allocation of cells. The contact was usually made by telephone or email, which is not problematic in itself, but this was not supported by timely record keeping or any backup measure.

I agree the recommendations made in the report for Chief Inspector QCS, if adequately implemented, would address those shortcomings.

Those recommendations were:

1. *QCS includes a specific question in the admission process about whether an offender has concerns about a prisoner who may be currently in the centre and the prisoners response be noted and communicated to the relevant decision makers.*

2. *QCS implements a procedure whereby relevant information obtained during the admission process is provided for the consideration of officers who conduct placement assessments.*
3. *CCC implements further training for officers in relation to intelligence processes.*

The inquest heard from the current General Manager of the CCC, Ms Paula May. She also submitted a detailed statement setting out the way in which these recommendations have been addressed. She candidly acknowledged that at the time of Mr Biddulph's death the system in place did not provide for adequate record-keeping. This meant there was no process in place to provide for the accountability of those notified of a prisoner's protection needs.

Ms May told the inquest that changes to QCS Admission and Assessment procedures, now implemented, mandate the questioning of incoming prisoners about whether they have concerns in relation to prisoners already in that facility. This is done as part of the IRNA process.

If such a concern is raised the new procedure also mandates a process of notification to relevant staff including, in a circumstance such as the one involving Mr Biddulph, the secure supervisor. The IRNA recording the details of the prisoner's response must now be completed within 24 hours and lodged on IOMS. The application for protection process would then proceed as it did in Mr Biddulph's case, but the notification of those in charge of cell allocation is no longer reliant on the discretion of one member of staff.

Finally, Ms May provided details of training that has been provided to CCC staff in relation to the recording and dissemination of information potentially relevant to the prison intelligence section. The facilities inherent in IOMS and designed for this purpose, including the use of 'intelligence notes', have been central to this training. It was clear from the evidence of Ms Misztal and Mr Toby that these changes had resulted in tangible changes to day to day procedure at the CCC.

In the circumstances I am satisfied no further recommendations need to be made.

I close the Inquest.

Michael Barnes
State Coroner
Rockhampton
13 November 2012