QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Jeremy Dylan BARKER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 4876/07(5)
DELIVERED ON:	08 October 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 March 2010; 28 - 29 April 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, hanging points, observation of "at risk" prisoners

REPRESENTATION:

Counsel Assisting:	Ms Julie Sharp
Department of Community Safety:	Mr Richard Perry SC (instructed by Dept of Community Safety)
GEO Group Australia Pty Ltd:	Mr Sandy Horneman-Wren SC (instructed by Blake Dawson)

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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 and to each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for aspects of the justice system. These are my findings in relation to the death of Jeremy Dylan Barker. 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, Jeremy Barker was an inmate of the Arthur Gorrie Correctional Centre (AGCC). He had a history of mental illness and was considered an "at risk" prisoner on account of articulated suicidal ideations and previous attempts. Mr Barker was therefore housed in the medical centre of the facility. Four days after arriving at the AGCC, fellow inmates found Mr Barker hanging in the toilet of the medical centre and raised the alarm. Medical attention was administered but he was unable to be revived.

These findings seek to explain how the death occurred, consider whether it could have been prevented and whether any changes to the prison and/or its policies and procedures, might reduce the likelihood of similar deaths occurring in the future.

The investigation

Efforts at resuscitation were discontinued at 3.32pm. By 4.40pm detectives from the Corrective Services Investigation Unit (CSIU), a specialist squad within the Queensland Police Service (the QPS) that investigates incidents within correctional centres, were at the scene commencing their investigation.

Those officers searched and examined the medical ward as did a senior scientific officer. Photographs were taken and statements were obtained from various corrective services officers (CSOs). The prisoners who were in the medical ward when Mr Barker died were interviewed, as were the prison officers on duty in that part of the jail and the medical centre nurses and doctors. A post-mortem examination was conducted on 23 October 2007.

The CSIU investigators produced a comprehensive report.

A separate investigation was undertaken by inspectors appointed by the Acting Chief Inspector, Queensland Corrective Services (QCS). Those investigators are to be commended for their robust inquiry into, and comprehensive report regarding, Mr Barker's death which has been of great assistance.

The Office of the State Coroner has made further inquiries relating to the management of other prisoners in the medical ward at the time of Mr Barker's death and has been assisted in those inquiries by the GEO Group Australia (GEO), which organisation privately manages and operates AGCC under contract to QCS.

As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased that he or 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 that 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 given at the 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 19 March 2010. Ms Sharp was appointed Counsel Assisting. Leave to appear was granted to the Department of Corrective Services, GEO Group and Queensland Health.

The inquest proceeded over two days commencing on 28 April 2010. Ten witnesses gave oral evidence and 62 exhibits were tendered. Since health care provided to Mr Barker by Queensland Health does not form part of the issues to be investigated at the inquest, Queensland Health elected not to appear at the inquest.

The evidence

I now turn to the evidence. Of course I cannot 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 Barker was born in Bernie, Tasmania on 26 September 1980 and was 27 years old when he died. He had three step-sisters, one of whom was celebrating her birthday on the day Mr Barker died. Mr Barker had a son who was three years old. His relationship with the child's mother was, it seems, a turbulent one.

Mr Barker's mother, Adele Sheehan, reported that her son had a normal childhood but developed signs of anger management issues in his late teens. Mrs Sheehan attributes her son's downward spiral to illicit drug use. That problem is borne out in Mr Barker's criminal history, which I will shortly outline.

Despite that, there was some cause for hope when, in April 2007, Mr Barker was dealt with by the Southport Drug Court and placed on an Intensive Drug Rehabilitation Order (IDRO) which saw him living at the Fairhaven Drug Rehabilitation Centre. Mrs Sheehan says that her son was proud of the progress he was making there and upbeat about his future.

Sadly, that optimism was dashed when Mr Barker was excluded from the program, apparently on account of embarking on a relationship with another resident who fell pregnant as a result. Mr Barker again went into a downward

spiral and was variously treated by the mental health unit at the Gold Coast and Maryborough Hospitals.

I take this opportunity to express my condolences to Mr Barker's mother, and other family members. Mr Barker's struggle in life was no doubt distressing for Mrs Sheehan in particular, and his premature death a very sad end to his turbulent and relatively short life

Criminal history

Mr Barker had a lengthy criminal history in Queensland commencing in May 2000 with a minor drug charge. Soon after he was convicted of a large number of property offences and was sentenced to 18 months imprisonment.

An intensive correction order was imposed in February 2004 for breaches of a domestic violence order, dangerous operation of a motor vehicle and serious assaults. That order was later breached when Mr Barker was convicted of drug offences and he was committed to probation for three years. It is apparent that by sentencing him to community based orders the courts made repeated efforts to encourage Mr Barker to deal with his drug addiction.

Those efforts were unsuccessful. Sadly, Mr Barker found himself incarcerated for another lengthy term when he was sentenced in Mt Isa, in September 2005, for another large swag of property offences. The term imposed on that occasion was three years, suspended after 12 months for an operational period of four years.

That suspended sentence was breached when he committed further property offences, but Mr Barker was given yet another opportunity in the form of an Intensive Drug Rehabilitation Order (IDRO) that required he reside in Fairhaven Rehabilitation and Detoxification Centre in Southport. As I have already mentioned, Mr Barker was excluded from Fairhaven as a result of breaching conditions of his residing there.

He remained on the Gold Coast for a few weeks and was admitted to the Gold Coast Hospital Mental Health Unit. He absconded and travelled to Maryborough where he came to police attention. He was initially held in the Maryborough Base Hospital Mental Health Unit on account of obvious symptoms of mental illness. He was there diagnosed and treated for Affective Bipolar Disorder.

When he was discharged he was again taken into custody and charged with a number of break and enter and unlawful use offences. Because that offending put him in breach of the IDRO Mr Barker was transported back to Southport, where the order had been made. By that time he was acutely unwell. From Southport he was transferred to the AGCC where he remained until his death.

Psychiatric history

Mr Barker was diagnosed with depression during his incarceration at AGCC in early 2007 and was successfully treated with Zoloft. He was then transferred to Fairhaven in accordance with the order of the Drug Court. After being

excluded from that facility, Mr Barker was without a fixed address and went without his medication for several months resulting in his admission to the Gold Coast Hospital for depression and suicidal ideation. An Involuntary Treatment Order (ITO) was made. Records show that Mr Barker was an inpatient from 8 August until 23 August 2007 when he absconded.

Mr Barker travelled to Maryborough and was almost immediately apprehended by police for allegedly committing further offences. He was admitted to the Maryborough Base Hospital and then to the mental health unit as a classified patient from 26 August until 3 October 2007. Mr Barker expressed suicidal ideations at that time and was diagnosed with bipolar disorder. AGCC records note he had tied a sheet to a door while in hospital at Maryborough but was discovered by a nurse before he could give effect his intention of hanging himself.

On about 3 October 2007, he was discharged from the Maryborough MHU. As detailed earlier, he was charged with break and enter and unlawful use of a motor vehicle, and some other offences dating back to 2000 and taken to the Southport Watchhouse.

On 12 October 2007, Mr Barker was reported by watchhouse staff to have been hearing voices. The Clinical Summary notes recent suicide attempts by overdosing on prescription medication (about 40 days prior) and by cutting his wrists (about three months prior). Mr Barker reported voices were telling him to self-harm and he told the visiting psychiatric nurse he would hang himself if he had the opportunity. That information was passed on to the Watchhouse Senior Sergeant and later to AGCC.

Records for 15 and 16 October 2007 confirm that there remained evidence that Mr Baker was suffering a mental illness, although at that time he did not meet the criteria for an ITO. He was referred to prison mental health services for monitoring and treatment and on 17 October 2007 was taken to AGCC.

Admission to AGCC

In accordance with prison procedure, Mr Barker was assessed upon admission into the centre on 17 October 2007. It is evident the prison authorities were aware of his recent hospitalisation at Maryborough and the recent suicide attempts. Importantly, records in evidence also make clear that staff at AGCC were aware that Mr Barker had expressed an intention to hang himself if given the chance.

Mr Barker reported he was taking medication but could not recall which drugs or the doses. He was depressed about having "*stuffed up again*" and the registered nurse performing the assessment described him as "*extremely quiet, flat, slow thinking and slow response, pale, somewhat 'out of it' and sleepy*." Mr Barker said ending his life was on his mind.

The Interim Risk Plan completed on admission deemed Mr Barker to be at risk of self-harm. The observation risk level was first determined to be category A but that was changed to category B meaning that rather than 10

minute observations Mr Barker was to be checked every 15 minutes. Registered Nurse, Tess Haimes explained the change was made after consulting with her supervisor.

On 18 October 2007, Mr Barker was seen by psychiatrist Dr Mann, of the Prison Mental Health Team. He did not have the benefit of Mr Barker's medical records but was able to ascertain that Mr Barker had been recently hospitalised and had been diagnosed with bipolar disorder. Mr Barker also disclosed he had undergone a course of electroconvulsive therapy (ECT).

Dr Mann noted that Mr Barker expressed a preference to be housed in the main unit rather than in the medical unit, stating that he felt safe and denied thoughts of self-harm, suicidality or aggression. Nevertheless, Dr Mann suggested that Mr Barker be housed in the medical unit. As one would expect, prison staff acted on that suggestion, although as I comment below, there was no consideration given to the risks that environment posed to Mr Barker.

Mr Barker was not able to say what medication he had previously been on so Dr Mann simply ordered that those drugs be continued once they were ascertained. The drug chart in his file shows that Mr Barker received Tegretol, Efexor and Diazepam daily from 18 October onwards.

He was housed in a 6 bed medical ward which was also occupied by two other prisoners

There is no evidence of any further examination or treatment of Mr Barker.

Events of 21 October

In the short time Mr Barker spent in the 6-bed medical unit, he was observed to be quiet and cooperative. He apparently did not present any problems for corrective services officers, nor did he exhibit any signs of deteriorating mental health or suicidal intention.

CSO Karl Winter was on duty in the medical ward on the weekend of 20 and 21 October 2007. He gave evidence that on Saturday Mr Barker "*was very happy".*

On Sunday morning, RN Janelle Kelly administered Mr Barker with his medication at about 7.00am. Ms Kelly knew Mr Barker from a previous period of his incarceration and knew him to have a history of self-harm or attempted suicide. She says she had a good rapport with him and did not discern any cause for concern during her conversation with him. That conversation included an exchange regarding Mr Barker's mental state and his sleep, mood and appetite which did not reveal any problem.

Ms Kelly saw Mr Barker again at about 10.00am when he presented with a splinter in his finger. He engaged in positive conversation with Ms Kelly at that time. She later described his apparent mood at that time as "*jovial*".

CSO Angeleena Johnson was the floor officer on duty in the medical ward over the weekend. She was being trained by Karl Winter. Shortly after 11.00am, she took the three inmates from the 6-bed ward, Messrs Barker, Commons and Ganzer, to the exercise yard for lunch and cigarettes.

During that period, Mr Barker asked Ms Johnson if he could telephone his sister who was celebrating her birthday. There is conflicting evidence as to whether Mr Barker was unable to get through when he made the call, or whether he was unable to make the call at all.

Ms Johnson recalled that she told Mr Barker he could not make the phone call because the number had not been cleared through necessary security procedures. According to Ms Johnson, Mr Barker did not appear disgruntled or agitated, rather he accepted the response that she gave him and appeared "*pretty happy*".

Inmate Ganzer's evidence at the inquest was that Mr Winter refused to allow Mr Barker to make the phone call saying words to the effect, "*You get nothing*". Mr Ganzer had not previously mentioned that in his various interviews and the suggestion was denied by Mr Winter. Mr Ganzer initially told police that he was uncertain about whether Mr Barker was refused the phone call and later, that the officer did give him the phone call. I am of the view his evidence in relation to this aspect of the matter is unreliable.

Mr Winter initially recalled Mr Barker attempting to phone his sister on Saturday, but conceded that might have happened on Sunday. Mr Winter thought that Mr Barker tried to make the call but could not get through because he saw the receiver being returned with a heavy 'clunk'. He recalls Mr Barker "*seemed fine, but….a little pissed off that he couldn't get through*".

Otherwise, Mr Winter did not observe anything that caused him concern about Mr Barker's mental state. Mr Winter had clearly thought a great deal about his dealings with Mr Barker since the death and said in evidence –

> *Even if you ask me after the event, did I think there was any issue with Jeremy, after the experience that I have had with other prisoners and I would still have said "No".*

Fellow inmates, Clayton Ganzer and Matthew Commons, gave accounts that Mr Barker was depressed on the day of his death. He had been looking forward to attending the Indy racing carnival that weekend and was missing his sister's birthday on account of his incarceration.

Ms Johnson says she did not notice anything out of the ordinary in respect of Mr Barker's behaviour that Sunday. She observed him walking around and changing the sheets on his bed. He handed in his dirty bed sheets and was issued with a clean set. Ms Johnson did not observe Mr Barker replace the sheets on his bed.

Later in the afternoon, when the three prisoners had returned from the exercise yard and were again locked in the medical unit, Mr Barker borrowed some paper from Mr Ganzer and appeared to be composing a letter. It seems likely this was the suicide note that was found after his death. Both Mr Ganzer and Mr Commons said that Mr Barker was crying either while he was writing, or just prior to doing so. Mr Commons observed Mr Barker leaning over his bed looking very dejected. Mr Commons dozed off for a short time and Mr Barker was lying quietly on his own bed.

A little later Mr Barker asked Mr Commons to roll a cigarette for him. A practice had developed between the three inmates where by they would take it in turns to go into the toilet to have a cigarette, using a lighter they had secreted there.

Mr Barker then went to the toilet. A few minutes later, Mr Commons went to use the toilet and asked Mr Barker how long he would be. There was no response and Mr Commons opened the door to find Mr Barker sitting on the toilet. About five to ten minutes later, Mr Commons reports returning to the toilet and giving some words of comfort to Mr Barker, along the lines of "*it's alright man, we love you, it's alright."*

The death is discovered

Twenty to thirty minutes after Mr Barker had first entered the toilet, Messrs Commons and Ganzer opened the toilet door to find their friend hanging. They raised the alarm by using the intercom to call CSO Winter at 2.57pm.

Mr Winter, along with Anne O'Brien and Roslyn Christie, two CSOs who had come to the medical centre to escort the nurse on the pill run, went immediately to the toilet where they saw Mr Barker slumped over on his knees with his back to the door. There was a sheet tied around his neck and to bars on the inside of the toilet window.

Mr Winter called the Centre Emergency Response Team (CERT). That team alerted other officers who responded quickly.

Ms Christie was tasked to retrieve the 'cut-down knife' which is usually kept in an emergency kit. Nurse Adair Behrends recalled that there was some difficulty locating the knife, however Mr Winter and Ms Christie denied this. Those officers said that Mr Barker was cut down within seconds. That is not supported by Mr Ganzer who recalled that it took three to four minutes to cut his friend down since no-one was in possession of a cutting implement.

Dr Hussain was present when Mr Barker was cut down. He could not find any signs of life. There was no respiratory movement and no audible heart activity. Mr Barker's pupils were fixed and dilated, his tongue was protruding and his face was swollen and blue. I consider it highly likely that Mr Barker was deceased at that time. However, appropriately, CPR was commenced and continued for approximately half and hour. A defibrillator was used and adrenalin administered. The Queensland Ambulance Service had been called

at 3.11pm and were at the scene by 3.18pm. The paramedics observations at 3.20pm were inconsistent with life.

Mr Barker was declared dead at 3.32pm.

The investigation detailed earlier then commenced.

Investigation results

A post-mortem examination was performed by Dr Nathan Milne at Queensland Health Scientific Services on 23 October 2007. Dr Milne concluded that Mr Barker's death was caused by hanging. He observed "*a red, partially band like abrasion/bruise on the neck consistent with a hanging injury."* There were no injuries to the neck seen on internal examination, however Dr Milne explained that that was not uncommon in deaths from hanging, particularly when a broad ligature such as a sheet is used.

Consistent with Mr Barker's history of self-harming, Dr Milne observed linear scars on the distal anterior left forearm. There were eight longitudinal and five traverse scars measuring up to 110mm and 40mm respectively.

There was no evidence to suggest the involvement of another person in Mr Barker's death.

Mr Barker's identity was confirmed by finger print comparison.

A note confirmed to be in Mr Barker's handwriting revealed the writer anticipated dying.

Findings required by s45

I am required to find, as far as possible, who the deceased was, how he died, when and where he died, and what caused the 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:-

Identity of the deceased	The deceased person was Jeremy Dylan Barker.
How he died	Mr Barker took his own life by hanging himself with a bed sheet from bars affixed to a window of the toilet in a ward of the medical centre of the prison where he was incarcerated and being kept under observation on account of his being assessed to be at risk of self harming.
Place of death	He died in the medical unit of the Arthur Gorrie Correctional Centre.
Date of death	Mr Barker died on 21 October 2007.

Cause of death Hanging.

Concerns, 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, or ways to prevent deaths from happening in similar circumstances in the future.

The aspects of this case which warrant consideration from that perspective are:-

- The presence of hanging points in the medical unit; and
- The observation of "at risk" prisoners

Hanging points

The exposed bars in the toilet window provided a convenient facility for a prisoner intent on suicide. They were positioned inside the glass; they were sufficiently strong to support an adult male's weight; they were secluded from any observation and the toilet pedestal provided an opportune step up. The prisoners in the ward had unrestricted access to the bathroom.

Two of the three prisoners in the ward were there because they had been assessed as being at high risk of self harm. In Mr Barker's case, the prison authorities had been explicitly warned he had expressed an intention to commit suicide "*by hanging if the opportunity arose."*

The obvious risks this combination of circumstances created were well known to those responsible for Mr Barker's custodial care. In July 2007, Mr Winter had sent an email to the jail's two Accommodation Managers, which he copied to the Operations Manager, wherein he expressed concern about the prisoners having unsupervised access to the toilet where they could not be seen.

In August 2007, another prisoner had attempted to hang himself in the 8 bed ward by securing a ligature to the bars on the windows. CSO Doug Clark had alerted the Accommodation Managers and the Health Services Manager. He also bought the matter to the attention of Maintenance Manager. Ominously Mr Clark concluded his email by saying; *"This needs urgent attention before we do have a suicide hanging."*

These concerns were not meaningfully responded by those managers or their superiors. They gave various, unconvincing excuses as to why this had occurred: it was somebody else's responsibility; it was already being addressed; and/or they didn't recall receiving the emails. The QCS Inspectors' report is justifiably critical of the inadequate response to the information given by the CSOs.

The prison General Manager wrote to each of the managers concerned expressing his dissatisfaction with their lack of response and indicating he expected them to be proactive in identifying and better managing such risks. He indicated formal disciplinary action could result if further lapses occurred.

The bars in both wards were covered with Perspex soon after Mr Barker's death. However, exposed bars in other parts of the facility continue to result in deaths. I shall analyse that on-going problem in future inquests.

Observation

As detailed earlier, Mr Barker was housed in the medical centre because he had been assessed as being at high risk of self harming. To reduce this risk it was ordered he be placed under 15 minute observations. The policies in place at the time made it clear this required an officer to go to the medical ward and observe the prisoner, not just view him over the CCTV. It seems Mr Winter may not have been aware of this requirement.

The last observation of Mr Barker recorded in the register used for that purpose was listed as having been made at 2.00pm, almost one hour before Mr Barker was discovered hanging. However, Mr Winter gave evidence that the observation log was incomplete and should not lead me to conclude that no further observations were carried out. Mr Winter says that either he or his colleague, Angeleena Johnson, did carry out the required observations at 2.15pm and 2.30pm.

Ms Johnson said that from 2.00pm onwards she was required to assist nursing staff on the medication round. During that time Mr Winter would not have been able to leave the monitoring station as he was the only other correctional officer in the medical centre. She had no knowledge of any observations being performed between 2.00pm and 2.57pm when the alarm was raised.

Mr Commons told investigators that he had not seen either of the prison officers since the time spent in the exercise yard at around lunch time.

I conclude that no officer went to the medical ward where Mr Barker was housed after 2.00pm. I accept it is likely Mr Winter viewed him from time to time over the CCTV while carrying out his other duties in the fishbowl but this was inadequate to detect the deterioration in his psychological conclusion. It is possible that had Mr Winter gone to the door of the ward at the required intervals he may have observed Mr Barker's distress when the latter was composing the suicide note and intervened. Alternatively, he may have become aware that Mr Barker was spending an unduly long time in the bathroom and investigated. He may have found the suicide note on the table beside Mr Barker's bed. He may have observed a sheet was missing from Mr Barker's bed. However, this is only speculation. I am unable to determine whether physical inspections as required by the correctional centre's policies would have definitely altered the outcome.

QCS required the prison operators, GEO Pty Ltd, to provide a detailed response to the concerns raised in the QCS Inspectors' report. GEO confirmed:-

- The results of the QCS Inspectors' report have been disseminated to all CSOs working in the relevant area;
- The observation policies have been reviewed so that all CSOs undertaking that duty are required to sign an acknowledgement that they have read the policy and understand what is required of them;
- An extra CSO is now rostered on whenever there are inmates requiring observation;
- Arrangements are being brokered with Prison Mental Health to provide training for correctional officers in dealing with prisoners suffering from mental illness; and, as mentioned earlier,
- The bars in the medical centre have been covered with Perspex.

Conclusions

Upon reception at the AGCC Mr Barker was correctly assessed as being at risk of self harming and in need of frequent observation. It was apparent he was suffering from severe mental illness. The prison authorities were made aware he had indicated he would hang himself if the opportunity arose. Despite this, Mr Barker was housed in a unit that had exposed bars in an area that could not be seen by the correctional officers responsible for monitoring him. Correctional officers had previously drawn management's attention to the risks these characteristics of the unit posed, but no action had been taken to address the problems. Mr Barker was given material from which a ligature could easily be fashioned and he was not monitored diligently. Sadly, but not surprisingly, Mr Barker took his own life four days after being admitted to the prison and before the pharmacotherapy he had commenced could be expected to have stabilised his mental state.

Individual and systemic failures combined to allow this preventable death to occur. The individuals have been counselled and the systems have been reviewed. I consider there is nothing further I can contribute to the prevention of deaths occurring in similar circumstances in future.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
8 October 2010