OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	Inquest into the death of Troy Samuel CROSSMAN
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 721/04(2)
DELIVERED ON:	3 February 2006
DELIVERED AT:	Brisbane
HEARING DATE(s):	29 and 30 August 2005
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, death in custody, management of 'at risk' prisoners, hanging points etc ….**

REPRESENTATION:

Counsel:

Assisting:	Mr Craig Eberhardt
Department of Corrective Services:	Ms Kay Phillipson
Borallon Correctional Centre:	Mr Scott McLeod
Family:	Mr Dennis Lynch

Findings of the Inquest into the death of Troy Samuel Crossman

Table of Contents

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, each of the persons or organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Corrective Services. These are my finding in relation to the death of Troy Samuel Crossman. They will be distributed in accordance with the requirements of the Act.

Introduction

In April 1999, in the Cairns District Court, Troy Crossman, who was then 28 years of age, was sentenced to imprisonment for six years and six months after pleading guilty to an offence of robbery with actual violence.

Mr Crossman was admitted to parole in April 2002, but within a week he breached a condition of his parole by consuming alcohol and he was returned to prison in May 2002. He served time at Wacol and Woodford correctional centres before being transferred to Borallon Correctional Centre (BCC) in December 2003.

On the night of 17 March 2004, Troy Crossman was found hanging in his cell. He was not able to be revived and was pronounced dead. These findings seek to explain how that occurred. With a view to assisting with the development of practices and procedures that might reduce the likelihood of similar future deaths, they also examine the appropriateness and adequacy of:-

- The procedures of BCC regulating the dissemination of information concerning the psychological state of prisoners to prison staff;
- The level of suicide awareness training given to prisoners; and
- Progress with the elimination of hanging points from prison cells

The Coroner's jurisdiction

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

The basis of the jurisdiction

Because Mr Crossman, was when he died, detained in a corrective services facility, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

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

[1] See s10
[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody

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

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will say something about the general nature of inquests however.

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

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

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

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

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

---

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

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

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Mr Crossman's death. As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or 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 it was in this case.

As soon as the ambulance officers who attended at the correctional centre to try and revive Mr Crossman advised prison staff that they had been unsuccessful and that the prisoner was dead, police were called and scene was secured. Uniform police from Marburg station attended and they contacted detectives from the Corrective Services Investigation Unit (CSIU), a specialist group from the Queensland Police Service (QPS) who undertake the investigation of all deaths and serious incidents in correctional centres.

About two hours after the death was discovered, officers from the CSIU arrived at the jail and commenced investigations. The scene was photographed. Relevant evidence within Mr Crossman's cell was photographed and secured. Witnesses were interviewed and statements obtained. A large number of relevant exhibits were obtained from the Borallon Correctional Centre.

On 19 March 2004 an autopsy was conducted by Dr Beng Ong a forensic pathologist from the John Tonge Centre.

The CSIU investigation report was forwarded to the Coroner in late 2004. Since then, further enquiries have been undertaken in relation to the

[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

management of prisoners with a history of self harm and/or suicidal ideation and the elimination of hanging points.

The Inquest

A pre-hearing conference was held in Brisbane on 29 June 2005. Mr Eberhardt was appointed Counsel Assisting. Leave to appear was granted to Mr Crossman's mother, the Management and Training Corporation (the operator Borallon Correctional Centre) and the Department of Corrective Services. A list of witnesses was settled and the issues to be examined during the inquest was agreed upon. The inquest then proceeded over two days on 29 and 30 August 2005. Twenty three witnesses gave evidence and 110 exhibits were tendered.

The Evidence

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

Background

As mentioned earlier, at the time of his death, Troy Crossman was serving a sentence of six years and six months imprisonment imposed upon him by the Cairns District Court in April 1999 for the offence of robbery with actual violence. It was not his first term of imprisonment; he had a reasonably lengthy criminal history for a variety of offences.

When he was initially taken into custody after breaching his parole, Mr Crossman was held at the Wacol Remand Centre until 24 July 2002 when he was transferred to the Woodford Correctional Centre. On 29 December 2003, Mr Crossman was transferred to the Borallon Correctional Centre. He remained there until his death on 17 March 2004. At the time of his death, he was residing in cellblock C6.

A perusal of Mr Crossman's prison medical file reveals a long history of relationship difficulties, depression, suicidal ideation and suicide attempts sufficient to persuade me that if other evidence indicates he died at his own hand, it could not be said to be inconsistent with this history. I shall return to this aspect of the evidence in more detail when dealing with the question of whether Mr Crossman's death was preventable.

The events of Wednesday 17 March 2004

Henry Gaulton was a prisoner in cell block C6. He was friendly with Troy Crossman, having met him sometime earlier when they both were incarcerated at the Woodford Correctional Centre. Mr Gaulton worked with Mr Crossman in the joinery shop. Mr Gaulton recalls that about three days before Mr Crossman's death, he noticed a change in Mr Crossman's mood and behaviour. He says that Mr Crossman was depressed and would not talk,

preferring to keep to himself. In the days leading up to Mr. Crossman's death, Mr. Gaulton described Mr. Crossman as being sad.[11]

On 17 March 2003, the day of Mr Crossman's death, Mr Gaulton was working with him in the joinery and asked Mr Crossman what was wrong. Mr Gaulton noticed that Mr Crossman was keeping to himself and did not appear to be feeling very well. He noticed that Mr. Crossman was not eating, not working as he normally did and did not look well. Mr. Gaulton gave evidence that Mr. Crossman appeared "*in pain.*" [12] Mr Gaulton questioned him and Mr Crossman informed Mr Gaulton that his relationship with his girlfriend had broken down.

Mr Gaulton did not raise any concerns about Mr Crossman's welfare with any custodial officers. He gave evidence that he did not think that Mr. Crossman would kill himself; had he done so, Mr. Gaulton would have told someone in authority.

James Everett was also detained in cell block C6 and he was also friendly with Mr Crossman. A few days prior to Mr Crossman's death, Mr Everett noticed that he was quiet and less sociable than usual. This so concerned Mr Everett that he asked Mr Crossman what was wrong. Mr Crossman informed him that he was having some problems with his ex-girlfriend.

On Wednesday 17 March 2004, Mr Everett was working with Mr Crossman in the joinery shop. Mr Everett noticed that he was very quiet and asked him what the problem was. Mr Crossman told Mr Everett not to worry. Mr Everett saw Mr Crossman later on in the yard of the unit when he observed that Mr Crossman's mood had not changed from earlier in the day. Mr Everett last saw Mr Crossman about at 6.30pm, at which time he observed him in the yard of the unit pacing up and down. Mr Everett did not raise any concerns about Mr Crossman with any prison officers. Mr Everett gave evidence that had he thought that Mr. Crossman may harm himself he would have told a prison officer.

Dale Hanley, a trade instructor responsible for the instruction and supervision of prisoners' work duties in the joinery, recalls that on the day of his death, Mr Crossman worked in the joinery from approximately 9.00am to 3.00pm. Mr Hanley recalls that Mr Crossman carried out his duties as required. Mr Hanley did not notice anything abnormal about his behaviour on that day.

Daniel Johnson was also an inmate of the Borallon Correctional Centre at the material time who considered that he was Mr Crossman's *"best mate in the unit block*". Mr Johnson noted that Mr Crossman became more "*within himself"* in the week leading up to his death. Mr Crossman confided in Mr Johnson that he was very depressed over the relationship problems that he was having with his girlfriend Renee Green. However, Mr Johnson says that he had no idea that Mr Crossman would kill himself.

[11] Transcript p132
[12] Transcript p133

Mr Johnson recalls that about two days before his death Mr Crossman ripped up all of the letters that Renee Green had written him and took down from the walls of his cell the photographs of Renee. Mr Johnson gave evidence that a few days before his death Mr Crossman stopped eating.[13]

Mr Johnson recalls that on Wednesday 17 March 2004 Mr Crossman did not eat very much and was really quiet throughout the day. There was no suggestion by Mr Johnson that Mr Crossman was troubled by anything other than the relationship difficulties he was having with Renee Green.

Jason Harding, a prisoner in cell block C6 who occupied a cell opposite Mr Crossman's, was also quite friendly with Mr Crossman. Mr Harding knew from another prisoner that Mr Crossman had tried to commit suicide before by setting himself on fire. Mr Harding knew that Mr Crossman's girlfriend had ended their relationship shortly before his death.

About two to three days prior to Mr Crossman's death Mr Harding saw Mr Crossman ripping up letters from his girlfriend. Mr Harding also noticed that Mr. Crossman was "*real quiet*" and "*wasn't eating*." Mr Harding did not tell anyone of his concerns because Mr Crossman's state of mind was "*pretty obvious."*[14]*.*

Mr Harding recalls that some time after 5.30pm on 17 March 2004, he saw Mr Crossman pacing around the yard with Daniel Johnson. Mr Harding recalls that at about 7.15pm he and other prisoners were locked in their cells.

Larissa Pope is a custodial officer employed by Management and Training Corporation at the Borallon Correctional Centre. She knew Mr Crossman, although not very well. Ms Pope describes Mr Crossman as being a quiet person who kept to himself. Despite being his unit officer she frankly stated that she did not have much contact with him.[15] However, she says that in the weeks leading up to Mr Crossman's death she observed nothing about him that gave her cause for concern that he might self harm.

Custodial Officer Bryan Maynard also knew Mr Crossman. Mr Maynard describes Mr Crossman as being fairly standoffish and very quiet. Mr Maynard knew that Mr Crossman was friendly with Mr Johnson. He was not aware of any issues that Mr Crossman may have had with any prisoners in his unit. Mr Maynard gave evidence that he had no idea that Mr Crossman intended to take his own life.[16] I accept Mr Maynard's evidence that he knew the signs which indicate a prisoner is at risk of self harm and I accept also that he did not notice those critical changes in Mr Crossman's mood and behaviour as described by the other prisoners.

At 7.30pm, Ms Pope and Mr Maynard locked Mr Crossman in his cell. Both gave evidence that they looked into Mr Crossman's cell and saw him sitting on his bed watching television with the light off. Mr Crossman was alone in the

[13] Transcript p162
[14] Transcript p144
[15] Transcript p29
[16] Transcript p50

cell. When Ms Pope locked Mr Crossman in, she says saw nothing that would suggest that Mr Crossman was about to commit suicide.[17] Neither Ms Pope nor Mr Maynard observed Mr Crossman to have any injuries or to be unwell at that time. As part of the lock down process all other prisoners in the cell block were accounted for.

The death is discovered

At around 9.15pm Mr Harding recalls looking through the window in his cell door and seeing something covering Mr Crossman's cell observation window. On closer inspection, Mr Harding thought he could see something underneath the door which looked like a shadow of Mr Crossman's feet. Mr Harding kept looking for a little while and then pressed the intercom button in his cell. Mr Harding says that there was no answer for about two to three minutes. When Mr Harding did speak to a custodial officer he informed the officer that he thought that Mr Crossman was hanging himself.

There was some conflict in the evidence about the time taken for this communication to be affected. The officer in master control who is responsible for responding to intercom communications from prisoners says that it is possible that a prisoner may take a few minutes to get through but he didn't think that it took that long on this occasion. I was not persuaded that the officer in question had a reliable memory of this particular incident and I am inclined to think the time he recorded on the shift log is the time when he responded to the call and not necessarily when the call was first made by the prisoner. However, for reasons that will become apparent later I consider nothing turns on this conflict of accounts.

The officers who were called by master control to respond to the information provided by Mr Harding give various estimations of when they were contacted ranging from 9.15 to 9.20. Ms Scates, a custodial supervisor says she was contacted at about 9.20pm and advised of what Mr Harding had alleged. She and four other officers ran to C block movement control post where she unlocked the key safe and removed the key for cell block C6 and gave it to one of the other officers who went immediately to that block while she relocked the safe.

One of those officers gave evidence that as he was making his way along cell block 6 to the end cell where Mr Crossman resided, he looked and saw that each of the other cells was properly locked.

Ms Scates then joined the other officers outside Mr Crossman's cell. She saw that there was a cloth obscuring vision into the cell. She saw one of the officers bang on the cell door and heard no response. She directed one of the officers to unlock the door, which he did. They were then confronted by Mr Crossman hanging from a ligature around his neck fastened to bars above the

[17] Transcript p34

door way with his feet just off the ground. His hands were tied together with strips of material and tied around his upper right thigh.

All officers agree that there was no one else in the cell. All agree that when he was cut down Mr Crossman had no pulse and he was not breathing.

Mr Harding agrees that some time after he reported his concerns he heard keys jangling and people running down the spine of the unit. Mr Harding's estimations of the time which elapsed after he called until these officers arrived vary widely and are not reliable.

Mr Harding was looking through the window of his cell door when custodial officers arrived at Mr Crossman's cell. When the door of that cell was opened, he saw Mr Crossman hanging in the doorway. His eyes were open.

Mr Harding saw custodial officers cut Mr Crossman down, place him on the ground and commence cardio pulmonary resuscitation. Mr Crossman did not exhibit any signs of life after he was discovered. Mr Harding is also sure that no one else was in Mr Crossman's cell at the time of his death.

Ms Scates radioed for a nurse and an ambulance. The nurse was already on her way. The ambulance was called at 9.24.

Resuscitation commences

At about 9.20pm Nurse Rachel Shields says she was advised that someone was hanging in cell block C6 and she immediately made her way there arriving at about 9.25pm. She says that when she arrived at the cell two officers were undertaking CPR. She then took control of the resuscitation attempts.

After Mr Crossman was brought out into the corridor, Nurse Shields felt for a cardial pulse but could find none. She noticed that Mr Crossman was not breathing. Nurse Shields applied a defibrillator to Mr Crossman. The machine indicated that Mr Crossman did not have a heart rhythm that was shockable. Nurse Shields told the officers to continue with cardio pulmonary resuscitation and she then listened with a stethoscope for an apical heartbeat but was unable to locate one. Nurse Shields and the custodial officers continued with CPR until the ambulance officers arrived.

The request for ambulance assistance was received at the Ipswich Ambulance Station at 9.26pm. It was immediately conveyed to the paramedics detailed to respond. Two vehicles containing four paramedics arrived at the correctional centre at 9.39 and were met by Ms Scates who escorted them to the scene. They arrived at the cell at about 9.43. Those people then took over the care of Mr Crossman.

One of the ambulance officers, Mr Kain, gave evidence that when they arrived Mr Crossman was unconscious and was not breathing. He was pale and his skin temperature appeared to be normal. Defibrillator pads were placed on Mr Crossman's chest and it was observed that his heart electrical activity was

asystole. The ambulance officers then commenced cardio pulmonary resuscitation and continued on with this for a period of time.

At 9.52pm Mr Kain contacted Dr Kylie Baker, Senior Medical Officer at the Ipswich Hospital, and after consultation in relation to Mr Crossman's clinical presentation and history, Dr Baker authorised Mr Kain to cease cardio pulmonary resuscitation on the basis that there was no chance that he could be brought back to life. At 9.52pm Mr Crossman was pronounced dead by the ambulance officers.

The investigation commences

His body was then placed back in his cell and covered with a blanket. The cell was locked. Police were called and the investigation detailed earlier in these findings was commenced.

All of the occupants of cell block C6 were interviewed and none says he saw or heard anything suspicious between the time when the prisoners were locked in their cells and Mr Crossman was found.

Located on Mr Crossman's desk was a note which said "*Please forward to my girl and friends.*" Ms Green identified the handwriting on this note as being Mr Crossman's. Amongst the documents were a number of handwritten letters to Ms Green and other friends of Mr Crossman. They appear to have been written over a number of days immediately prior to the death. It is clear from the contents of these letters that at the time of writing them Mr Crossman was contemplating ending his life.

The telephone calls made by prisoners are tape recorded. On the evening of his death, in three calls made by Mr Crossman to Ms Green, Mr Crossman makes fairly explicit his expectation that he would not be able to talk with her ever again after that evening.

An autopsy was conducted by a forensic pathologist, Dr Beng Ong on 19 March 2004 at the John Tong Centre Brisbane. In his opinion, the cause of death was hanging. Having regard to the small amount of bleeding that accompanied the facture of the hyoid bone and the thinness of the ligature, Dr Ong opined that Mr Crossman died within seconds or no more than a couple of minute of his being suspended. Lividity that he found in the soles of Mr Crossman's feet led Dr Ong to conclude that Mr Crossman had been dead for at least an hour when he was found and cut down. This opinion may seem inconsistent with the evidence of the ambulance officers that Mr Crossman's body temperature seemed normal to the touch. However in view of Dr Ong's evidence that a body does not appreciably cool for approximately two hours, I consider no conflict exists.

Dr Ong confirmed that no resuscitation could have been successful in the circumstances.

He found no suspicious injuries on Mr Crossman's body. Dr Ong noted a small abrasion on the bridge of the nose which, in evidence he described as

"*a very non specific injury that one can get at any time."*[18] He accepted the suggestion of counsel assisting that it may have been caused by Mr Crossman swinging against the door or door frame when he hung himself.

There were no other injuries on Mr Crossman's body apart from those caused by the ligature around his neck. That injury was consistent with the body being suspended by the ligature as distinct from being strangled by it.

Mr Crossman's mother alleged that when she viewed her son's body she noted numerous injuries to his face. However, this evidence is not supported by the photographs of the body or the examination made by Dr Ong. I conclude that the mother must be mistaken.

In Dr Ong's opinion, the bandages found tied around the wrist and thigh of Mr Crossman were loose and could have been tied by the deceased. In particular, Dr Ong noted that there was no injury to the wrists caused by the bindings as would be expected if Mr Crossman was struggling while another person overpowered and bound him.

A week or so before his death, in the last conversation he had with his mother, Mr Crossman spoke of his determination to be more constructive with his life after release from prison and to make more of his relationship with Renee. Understandably, this has made it difficult for his mother to accept that Mr Crossman took his own life.

However, the following aspects of the matter support the conclusion that Mr Crossman intentionally caused his own death:-

- the history of depression, suicidal ideation and previous attempts;
- his distress at the breakdown of his relationship with Renee Green;
- the implied threats of self destruction made in his final telephone calls with Ms Green;
- the indicators of depression - loss of appetite, withdrawing etc witnessed by the other prisoners;
- the contents of the letters found in his cell;
- evidence that he was alone in his cell when it was locked and when he was found dead; and
- the autopsy evidence indicating injuries consistent with hanging and an absence of evidence of any third party involvement.

I am also satisfied that the prison authorities responded expeditiously to the advice that someone was hanging and that the first aid given was appropriate. I consider that no action of any officer or other prisoner caused or contributed to the death.

[18] Transcript p193

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner of 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 in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Troy Samuel Crossman

Place of death – He died in cell bloc C6 at the Borallon, Correctional Centre, Borallon, Queensland

Date of death – Mr Crossman died on 17 March 2004

Cause of death – He died from self inflicted hanging.

Concerns, comments and recommendations

Section 46, in so far as is it 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. I have found that none of the prison officers or other prisoners caused or contributed to the death and that nothing more could have been done to save Mr Crossman after he was found hanging. That does not mean that the death was not preventable or that the cells at Borallon could not be made safer. In particular, for the reasons set out below, I consider there may be a basis for concern about the way the authorities at Borallon responded to the information about Mr Crossman's risk of self harm and the prevalence of hanging points in the cells. I will now deal with each of those issues in some more detail.

Response to information about risk of self harm.

There was at the time of Mr Crossman's death, voluminous information accessible to Borallon Correctional Centre staff indicating that he was acutely at risk of suicide yet no precautions were taken to guard against him self harming. There is no suggestion that callous disregard played any part in this failure but in my view, it suggests a review of how information is gathered and disseminated in the prison may be warranted.

Information indicating Mr Crossman was at risk of self harm was available from four sources; the Corrective Services Commission/Department medical file, the observation of other prisoners, the letters in Mr Crossman's cell and the tape recordings of the telephone calls made by Mr Crossman on the day of his death. I readily accept that the authorities could not be expected to have accessed the information in the unfinished letters and I will therefore say

nothing more about that. The position in relation to the other sources of information is not so clear cut. I shall deal with each of them separately.

Information on file

Mr Crossman's prison medical file which travels with the prisoner from jail to jail has numerous, detailed entries noting a long and extensive history of depression, suicidal ideation and suicide attempts.

Upon arrival at the Borallon Correctional Centre on 29 December 2003, Mr Crossman was assessed by Ms Merilee Booth, registered nurse. Ms Booth would seem well qualified to undertake this task. She was first registered in 1989 and obtained her psychiatric endorsement in 1993. Prior to working at the Borallon Correctional Centre, she worked for Queensland Health as a clinical nurse performing psychiatric assessments for the West Moreton Public Health Centre for approximately 14 years.

When undertaking this assessment the nurse had access to the medical file on Mr Crossman referred to above and he informed her that he had a history of depression and suicide attempts, including attempted self harm with a shot gun and self immolation.

However, as a result of responses he gave to her questions, Nurse Booth assessed Mr Crossman as having no current depression or suicidal ideation. Nurse Booth decided that he was not in immediate danger of self harming and she considered no further action was warranted at that time. As a result, the details of Mr Crossman's history of depression, suicidal ideation and self harm were not communicated to anyone involved in the day to day management of Mr Crossman.

Nurse Booth gave evidence that at the time of her assessment of Mr. Crossman in December 2003 it was not general practice at the Borallon Correctional Centre to notify prison staff of a prisoner's history of self harm or suicidal ideation unless the prisoner was displaying current symptoms.[19]

The potential negative impact of this policy on prisoners such as Mr Crossman was exacerbated by his reluctance to seek assistance for his psychological problems. There are numerous entries in his file indicating that Mr Crossman was resentful of the usual response to his disclosing suicidal thoughts. For example, in April 2003 Mr Crossman told a psychologist at Woodford Correctional Centre that he was not willing to engage with psychologists and/or counsellors due to his frustration with being placed on observation each time that he disclosed suicidal thoughts.[20] Mr Crossman's apparent reluctance to seek help clearly exacerbated the risk of him self harming.

The fact that Mr Crossman was continuing to suffer problems but was no longer willing to seek help from prison authorities, made it imperative that those who had the day to day management of Mr Crossman be made aware

[19] Transcript p181
[20] Letter of Dr Chen dated 1 September 2005

of his history in order that they could keep a close eye upon him, particularly in times of personal distress. Two custodial officers who had dealings with Mr Crossman gave evidence at the inquest to the effect that had they been made aware of Mr Crossman's history, they would have paid greater attention to his welfare by looking for any changes in his demeanour or conduct.

As mentioned earlier, Nurse Booth claimed that the information was not passed on because there was no policy requiring her to do so at the time. This view is not supported by the report of the inquiry into the death undertaken by the assistant general manager of the prison.

That report included the following:-

> "Department of Corrective Services (DCS) procedure '*Suicide Prevention'* requires that '*where available information indicates that an offender has previously made an attempt to suicide/self harm or has displayed previous suicidal behaviour, whether in custody or not, this information must be communicated to staff involved in the management of that offender*.'
>
> A review of the case file reveals that there were several references in case notes to Troy Crossman being "on obs" or "off obs" but no documentation indicating frequency, duration and nature of his risk level. Nor was there any information pertaining to his individual high risk triggers/situations which required monitoring. Case notes made in the medical file and reception to BCC reveals that the reviewing RN was aware of his suicide/self harm history. However there was no indication that this information was relayed to Custodial Staff."[21]

Nurse Booth gave evidence that since Mr. Crossman's death the practice has changed such that it is now routine for this type of information to be communicated to prison staff in the form of a Special Needs of Prisoner Assessment ("SNOPA").

It is clear that the policy and practice in relation to the dissemination of information relating to a prisoner's history of self harm and related issues has tightened up significantly since Mr Crossman's death. It is now apparently the practice that a special needs of prisoner assessment is conducted by a psychologist upon a prisoner being received into the Borallon Correctional Centre. A copy of this assessment is then placed in the prisoner's file where it can be viewed by any prison officer who reads and reviews the file. In addition, the fact that a prisoner has a history of self harming behaviour, or is currently displaying self harming behaviours is flagged on the Integrated Offender Management System (IOMS) such that any prison officer opening a particular prisonon's file has that fact brought to his attention.

[21] Exhibit 1.33, paragraph 5.1.3

Both of these initiatives are clearly worthwhile, but it must be remembered that such systems only work if those who are charged with the day to day care of prisoners in fact access and read the relevant files. It is noteworthy that Ms Pope gave evidence that since the death of Mr Crossman the only change to relevant policy is that if a prisoner is detected to be at risk in the prison, custodial officers are notified. She was of the belief that if, for example, a prisoner has a history of self harming at another institution that would not normally be disseminated to BCC custodial officers.[22] Ms Pope's evidence can to be contrasted with the evidence of Mr Maynard who suggests that the new system is working very well.[23]

It seems the correctional authorities recognise the importance of making this information available to custodial officers but unless those who have the day to day care of prisoners actually access the information it will not inform their actions. The evidence given to the inquest indicates that currently there is no system that enables prison management to assess whether custodial officers are utilising that access.[24]

Recommendation 1 – Auditing of IOMS

I therefore recommend that the Department of Corrective Services investigate the viability of adding an auditing function to the Integrated Offender Management System (IOMS) to enable the level of compliance with policy concerning the accessing of "at risk" information to be assessed.

The observation of other prisoners

In the days leading up to his death, Mr Crossman displayed behaviour which concerned other prisoners in his unit. In particular, other prisoners variously observed:-

- a loss of appetite;
- a depressed mood;
- expressions of grief and anxiety about the breakdown of his relationship with Renee Green;
- the destruction by Mr Crossman of his photographs of Renee Green;
- the description by Mr Crossman of prior self harm attempts.

Despite making these observations, none of the prisoners were concerned that Mr Crossman might attempt to harm himself and accordingly none of them thought to warn any prison officer of such a risk

These observations were in contrast to those of the prison officers involved in Mr Crossman's care, none of whom detected anything out of the ordinary. This is hardly surprising given that an officer is usually responsible for supervising up to 33 inmates. It would be unrealistic to expect that a prison

[22] Transcript 30
[23] Transcript 48
[24] Evidence of BCC Assistant Manager Ms Roeder, transcript 207, 213

officer in the position of Ms Pope or Mr Maynard would necessarily pick up subtle, but significant changes in behaviour, even if he or she was aware of a significant history of self harming behaviour on the part of a particular inmate. This observation is not intended as a criticism of the prison officers involved, but serves to highlight the desirability of making prisoners more aware of the issue of suicide and fostering open lines of communication between prisoners and prison officers.

The prisoners who observed changes in Mr Crossman's behaviour in the days and weeks leading up to his death did not appreciate the significance of what they were observing. Had they done so, it seems likely that at least some of the prisoners might have brought their concerns to the attention of prison officers. While it cannot reasonably be expected that prisoners will always act in a responsible and community minded way towards their fellow prisoners, it is at least possible that some prisoners, if armed with the necessary knowledge and reassured in relation to the reporting and response procedure to be adopted by the authorities, will report their concerns. This may save lives.

In my view it is reasonable to expect that a suicide awareness and prevention campaign, coupled with appropriate assurances from the prison authorities that any notifications would be treated confidentially is likely to improve the flow of information to the authorities, which will help the authorities to better manage those prisoners who are at risk of self harm.

After the inquest, I received from the Department of Defence material briefly describing the ADF Suicide Prevention Program.[25] I do not mean to suggest that prisoners and armed servicemen are identical but it seems likely that there are some similarities between the cohorts that might make the lessons learnt by the ADF in their effort to address this problem among their troops relevant to the issue here under discussion. The material was therefore circulated to the parties.

The Department of Corrective Services responded expressing some concern that such a process might have unintended negative consequences including prisoners maliciously reporting suspicions of self harming tendencies in others to cause the subject embarrassment or inconvenience and/or a risk of the subject of a report retaliating against those they suspect of being responsible for a report.

However, in advice that seems inconsistent with those concerns, the Department also informed the Court that it had recently produced a series of posters highlighting the risk of suicide among prisoners and inviting anyone with knowledge of prisoners at risk to advise the prison management. The Department also advised that it provides to prisoners an information booklet which discusses the need to be aware of the indicators of self harm in oneself and in others.

[25] Exhibit 2.24

The Department correctly, in my view, suggests that research into the effectiveness of such a program should be undertaken before such a scheme were introduced. I would be surprised if a literature search did not reveal information about such programs in other prison systems. In my view part of that investigation could usefully involve a trial among a small group of inmates in a suitable facility.

Recommendation 2 – Suicide awareness training for prisoners

I recommend that the Department of Corrective Services examine the effectiveness and feasibility of introducing a suicide awareness program in all prisons aimed at encouraging prisoners to report observations that might indicate fellow prisoners are at risk of self harm. I recommend that as a part of that investigation a limited trial be undertaken in an appropriate facility.

The tape recorded telephone conversations

The third source of information concerning the level of risk of Mr Crossman self harming was the Arunta tapes. A recording of a telephone call made by Mr Crossman on the day of his death to a woman with whom he had enjoyed a close personal relationship was tendered into evidence. In it Mr Crossman makes clear his intention to end his life. There is no evidence that anyone other than the woman to whom the call was made heard the conversation before Mr Crossman took his life. The question this raises is whether prison authorities should more closely monitor telephone calls.

All telephone calls made by prisoners are recorded, presumably to safeguard against arrangements being made that could compromise the security of the institution and/or for the smuggling of drugs or other contraband into the prison.

That mechanism will only contribute to those very necessary goals if somebody listens to the tape recordings or monitors the conversations as they occur. Presumably, a decision to do either of these things is based on an assessment of the risk the prisoner poses. I can accept that it is not feasible to monitor all conversations as they occur. However, it seems unacceptable that authorities tape record conversations that, as in this case, contain strong indication of an impending suicide and those recordings are put to no use other than as exhibits in the caller's inquest.

Recommendation 3 – Monitoring of telephone calls of at risk prisoners

The changes made to prison procedures since this death and the other recommendations made in this inquest should, if properly implemented, contribute to the Department developing a more sophisticated and comprehensive system for assessing the level of risk of self harm of individual prisoners. I recommend that such a system include the monitoring of the telephone calls of those identified as being at risk.

Hanging points

The Royal Commission into Aboriginal Deaths in Custody, in its final report recommended hanging points be eliminated from watch houses and prisons cells.[26] The State Government accepted that recommendation and committed to implementing it. Obviously this had not occurred at the BCC at the time of Mr Crossman's death and so I wrote to the Department of Corrective Services asking what steps had been taken to implement the recommendation. I was advised that in fact only 63% of all cells currently in use are suicide resistant; that is, 15 years after the Government indicating it accepted the recommendation one third of all cells are still in a dangerous state.

In this case, the prisoner hung himself from bars above the cell door. Obviously those bars could easily be covered with mesh that would have minimal impact on ventilation while eliminating them as a hanging point. The excuse contained in a letter received from the Acting Director General of the Department to the effect that screening the bars in question might only divert prisoners to other hanging points is spurious and suggests a lack of commitment to this quite basic reform. Research has repeatedly shown that any interference with an opportunity to commit suicide can deter and prevent other attempts succeeding. The inability of the Department to immediately eliminate all hanging points should not be used as an excuse not to remove any.

Recommendation 4 – Screening of the bars above the cell doors

I recommend that the Department of Corrective Services immediately cover with mesh any bars accessible to prisoners in cells at Borallon Correctional Centre and continue with its program to make suicide resistant all cells in use in the prison system.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
3 February 2006

[26] Royal Commission Aboriginal Deaths in Custody, Final Report, volume 5 , recommendation 165