OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of **Randall John Coleman**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Kingaroy
FILE NO(s):	COR 2673/06(1)
DELIVERED ON:	10 July 2009
DELIVERED AT:	Kingaroy
HEARING DATE(s):	6 – 9 July 2009
FINDINGS OF:	Ms Christine Clements, Acting State Coroner
CATCHWORDS:	CORONERS: Death in custody, Strychnine poisoning

REPRESENTATION:

Counsel Assisting:	Mr Simon Hamlyn-Harris
Senior Constable Terry McCullough, Constable Jonathan Colquhoun:	Mr Glen Cranny (Gilshenan & Luton)
Commissioner of Police:	Ms Rebecca Treston (QPS Solicitor)
Queensland Health:	Mr Kevin Parrott (Crown Law)

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 organisations 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 Police and Corrective Services. These are my findings in relation to the death of Randall John Coleman. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

On the afternoon of 18 January 2007 Randall Coleman was a prisoner in the Kingaroy Watchhouse where he had been in police custody for more than two days. After attracting the attention of a police officer he claimed to have intentionally ingested an amount of strychnine. He showed the officer a vial containing a pink substance and, when asked, said it had been secreted into custody in his sock.

Mr Coleman was immediately taken to Kingaroy Hospital. He initially denied that he had taken strychnine but within 10 minutes began to suffer cramps and he admitted he had ingested strychnine. Consistent with the expected symptoms of strychnine ingestion, he then began to experience muscular spasms and convulsions before going into cardiac arrest. Attempts to revive him were unsuccessful and he was declared deceased at 4:20pm. He was 39 years of age.

Mr Coleman's 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]

These findings

- confirm the identity of the deceased man, the time, place and medical cause of his death;
- explain how he died and examine the events leading up to his death;
- examine the procedures in place for the searching and monitoring of prisoners at Murgon and Kingaroy watchhouses;
- examine the medical care afforded to Mr Coleman at Kingaroy Hospital;
- recommend changes to the allocation of resources at Kingaroy police station to allow for more effective monitoring of prisoners.

[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. s27 requires an inquest be held in relation to all deaths in custody

- raise issues for consideration concerning the elevated risk of self harm for prisoners where there are multiple stressors identified.

The investigation

The investigation was conducted by Inspector Ken Orme of the QPS Internal Investigations Branch, Ethical Standards Command (ESC). Inspector Orme liaised with the Office of the State Coroner at an early stage and later submitted a detailed report of his investigation and findings.

ESC officers travelled to Kingaroy on the evening of 18 January and commenced the investigation. Detective Sergeant Paul Austin had earlier travelled to Murgon where he secured the cell in which Mr Coleman had been held. The relevant cells and exercise yard in the Kingaroy watchhouse were secured by Sgt Robert Barclay of Kingaroy station until ESC officers arrived. Sgt Barclay also initiated a running log of events associated with the scene at Kingaroy. All relevant custody documents were seized from both locations. These were analysed with reference to QPS operational procedures and local standing orders relating to watchhouse procedure.

Investigators organised for scenes of crime officers to attend Kingaroy and Murgon. Photographs were taken of the relevant scenes and of Mr Coleman's body. Swabs were taken from various points in the Kingaroy watchhouse, from Mr Coleman's socks and boots and from the vial purportedly containing strychnine. These were sent for forensic testing both to detect the presence of strychnine and to assist in determining how Mr Coleman may have secreted the vial into custody. DNA analysis was conducted on a swab taken from the top of the vial and tested against that of Mr Coleman. Mr Coleman's socks and boots were bagged and fingerprinting of various areas of the watchhouse undertaken.

Interviews were conducted with a large number of witnesses including all police officers who had been in contact with Mr Coleman in the days leading up to his death; other prisoners; treating medical staff from Kingaroy Hospital; counsellors providing mental health services to Mr Coleman; his mother, estranged partner and neighbours; his legal representative, and a Department of Child Safety officer who had interviewed him the day before his death. Several police officers involved provided samples of urine under direction.

Investigators accessed all police records relating to Mr Coleman. Copies of medical records from Kingaroy Hospital and Kingaroy Family Care Centre were obtained. Investigators commissioned an expert analysis of the medical care provided to Mr Coleman at Kingaroy Hospital.

A search warrant issued pursuant to the *Coroners Act 2003* was executed on Mr Coleman's property and a quantity of strychnine seized. Checks were

conducted in relation to an expired permit for the possession of strychnine found on the property.

The contents of the vial, a pink powder, was analysed by High Performance Thin Layer Chromatography and compared to the strychnine found on Mr Coleman's property.

Two officers were interviewed in relation to an anonymous complaint made to the Crime and Misconduct Commission alleging rough treatment of Mr Coleman by police on his arrival at hospital.

Mr Coleman's body was guarded in the Kingaroy Hospital Morgue. At this time Mr Coleman's mother formally identified his body to police. Fingerprints were taken from the body and matched to those held on police records for Randall John Coleman. The body was then transported to Queensland Forensic and Scientific Services at Salisbury where a full internal autopsy was conducted on the morning of 19 January 2007.

In later months investigations were conducted into various people who were alleged to have had a beneficial interest in Mr Coleman's death by his estranged partner, Ms Rita Ashby. These did not give rise to any concerns or further lines of inquiry.

I have found the police investigation in this matter to be extremely thorough and professionally conducted. I take this opportunity to thank Inspector Orme for his considerable efforts.

The inquest

An inquest was held at Kingaroy from 6 to 9 July 2009. Mr Hamlyn-Harris was appointed as counsel to assist me with the inquest. Leave to appear was granted to the Commissioner of Police; two officers involved in the monitoring of the deceased while in custody; and the Queensland Department of Health.

Mr Coleman's mother and his defacto partner, Ms Rita Ashby, were notified of the inquest. Ms Ashby attended the inquest as an observer having earlier assisted the court by providing information via correspondence. This material was tendered as an exhibit. She did not wish to give oral evidence.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. This amounted to 182 exhibits. In addition, 31 witnesses provided oral evidence.

The evidence

I do not refer to 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. I note these findings

have been prepared without access to transcript and I reserve the right to amend and correct them prior to final publication.

Social history

Randall John Coleman was born on 27 October 1967 in Kingaroy as the only child of Wally and Carol Coleman. He grew up on his family property and attended Kingaroy State High School until the age of 16.

After school he worked as a farmhand and later as a semi-trailer driver. He was evidently a very hard worker having saved enough money to buy into his family property at a young age. He commenced a relationship with Noelene Burton in 1997 and their marriage produced two children. That marriage ended acrimoniously resulting in ongoing custody issues concerning the children. There was consistent evidence at the inquest that Mr Coleman was regarded as a good and loving father.

Mr Coleman began a relationship with Ms Rita Ashby in 2004 which continued until his death. Ms Ashby attended all 5 days of the inquest and has kindly provided the court with a detailed account of that relationship. It is clear that Ms Ashby and Mr Coleman were devoted to and loved each other. They clearly shared common interests and had planned for the future together. It was though, on occasions, a volatile relationship. This was increasingly so in the weeks leading up to Mr Coleman's death and it led to several actual and threatened physical assaults on Ms Ashby. Mr Coleman clearly suffered from a degree of depression and had difficulty dealing with anger. These problems had not, sadly, been professionally addressed as early and as thoroughly as would have been desirable. This was despite attempts by Ms Ashby and other friends to encourage him in this direction.

It is evident that Mr Coleman is, and will continue to be, very sadly missed by his mother (who survives him), his children, his friends and of course by Ms Ashby.

Background events

Chronology of events

Mr Coleman had a recent history of contact with police commencing on 2 January 2007 after an alleged incident of domestic violence against his de facto wife, Rita Ashby.

He was arrested in Kingaroy and briefly detained while Plain Clothes Constable Colquhoun completed an application for a domestic violence protection order and charged Mr Coleman with assault occasioning bodily harm. From this it can be inferred the allegation was considered a serious offence and that Rita Ashby was in need of protection pursuant to the *Domestic and Family Violence Protection Act 1989.*

Mr Coleman was briefly detained before being released with a notice to appear on 4 January 2007. He co-operated with the police officer and made full admissions. Police officers considered he was very calm and remorseful.

The next day, on 3 January, Rita Ashby contacted police again. She was concerned Mr Coleman may commit suicide. He was last seen riding away from the property on a motorbike with a rifle slung over his shoulder. Senior Constable Aboud and Sergeant Byrne attended the property at Maidenwell and spoke with Rita Ashby and a neighbour, Neil Vandersee. Mr Coleman eventually returned to the property but indicated he had hidden the firearm in the bush. He expressed his fear to police of being sent to jail over the recent charges. Sergeant Byrne who attended the scene later was proactive in negotiating and assisting Mr Coleman to attend mental health counselling at Kingaroy later that day.

Ms Ashby showed the attending police a letter written by Mr Coleman. It detailed the various stressors in his life, including his fear he would lose the farm in unresolved property litigation with his former partner. He considered he had lost his children and there was nothing to live for. The letter was not retained by police. It was suggested it be shown to the counsellor but Ms Ashby decided not to reveal that document to the counsellor later that day.

Rita Ashby attended the initial appointment when Mr Coleman consulted with a psychiatric nurse, Stuart Pledger. Mr Pledger gave evidence at the inquest and noted that on this first occasion much of the information was provided by Ms Ashby. He recorded Mr Coleman had anger management issues as well as relationship issues and he queried whether he may also have depressive symptoms. He went on to record Mr Coleman had been charged with assault and bodily harm. His notes detailed dyslexia and problems with comprehension and a dependence on his partner to assist in communication. Multiple stressors including financial problems, family law disputes with the mother of his children involving both property and contact matters as well as resultant legal expenses were all noted. Mr Coleman expressed his frustration with authority.

A specific notation of no psychiatric history and no history of depressive illness was made but Mr Pledger considered Mr Coleman needed follow up, particularly regarding the issue of possible depressive illness.

Mr Pledger clearly considered Mr Coleman was exhibiting sufficient signs of distress to warrant a referral for mental health care but he did not consider him to be suicidal. His notes were detailed but there is no reference to the details of the incident that had occurred that morning. I accept his evidence.

Mr Coleman was seen again on 10 January. On this occasion Mr Pledger spoke with Mr Coleman in the absence of his partner. This was entirely appropriate to enable a proper assessment to be made and provide an opportunity for Mr Pledger to build rapport with Mr Coleman. A referral to

mental health services was made as Mr Pledger considered this would be helpful. Overall he considered Mr Coleman to be at moderate risk of self harm although he denied current suicidal thoughts and denied homicidal thoughts. He expressed he felt sad and irritable but he still expressed hope for the future.

The interview was detailed and had regard to Mr Coleman's stated commitment to his relationship with Rita. It was agreed he would see Mr Pledger again and arrangements would be made for an appointment with a psychiatrist.

The next day Mr Pledger received a referral form Dr Isabelle Jonsson, Mr Coleman's treating general practitioner. She was requesting an assessment of Mr Coleman and indicated he was suffering from reactive depression. She had prescribed an antidepressant. Mr Pledger considered her diagnosis to be consistent with his assessment of Mr Coleman.

Mr Pledger was unaware of the serious incident that developed later on the same evening of 10 January 2007. He was surprised when he heard of it. Rita Ashby reported to police Mr Coleman had again assaulted her and threatened to kill her. The neighbour, Neil Vandersee, who had known Mr Coleman all his life, confirmed Rita's complaints with police. Rita had sought his assistance after escaping Mr Coleman by running away down a creek. The description of the assault was quite severe. Ms Ashby told her neighbour and police she had been thrown to the ground, strangled and bashed. Mr Vandersee knew Mr Coleman well enough to consider the risk and he decided to attend on Mr Coleman's property in the hope of calming the situation. He knew Mr Coleman well enough to consider it unlikely Mr Coleman would carry out any threats against himself, although he did consider Rita was at continuing risk from Mr Coleman.

When Mr Vandersee found Mr Coleman, he told Mr Vandersee he had trashed the house where Rita lived and would set fire to it. There were also allegedly threats made against police although it is not clear that this was communicated to the police. When giving his evidence Mr Vandersee remarked he knew Randall and that he often said things he did not mean.

Police officers attended but were unable to immediately locate Mr Coleman. Eventually, in the early hours of 11 January he surrendered to police after negotiations via phone which allowed him to have a shower and change at his neighbour's home before leaving the property with the police.

He was charged with assault occasioning bodily harm, wilful damage and possession of an unlicensed firearm. The firearm was recovered after daylight with assistance of Mr Coleman who directed Plain Clothes Constable Colquhoun to the location. Officer Colquhoun and others had a long night in resolving this episode to a peaceful conclusion.

On 11 January Mr Coleman was remanded in custody at Kingaroy to re-appear the next day. As the Kingaroy Watch house is designated a holding facility only, he was transported to Murgon Watchhouse overnight before being returned to Kingaroy on the morning of 12 January. He appeared before the Magistrate's Court and was granted bail and released on his own undertaking to appear on 15 February 2007. The bail conditions included a "no contact" clause relating to Rita Ashby and a condition he reside with his cousin at Maclagan or other address approved by the Officer in Charge of Kingaroy Police.

Unfortunately Mr Coleman did not obey the conditions imposed pursuant to the order of the Magistrate when bail was granted. He was arrested on 16 January 2007 at his farming property after Rita Ashby contacted police at about 7.50am that day. She informed police he had breached his bail conditions by returning to the property to live with his mother in the second house on the property and by contacting her. Officer Colquhoun attended at the property and spoke briefly with Mr Coleman's mother before entering the house, led by Mrs Coleman. She opened the door of a room towards the back of the house where Mr Coleman was speaking on the phone. He immediately told the person with whom he was speaking that the police were there and he had to go. It is unknown whether he knew the police had arrived at the property by his own observation, or perhaps in the course of the telephone call. In hindsight it is probable he did know the police had arrived and took the opportunity to secrete a small vial of strychnine somewhere on his person before being escorted from the house by Plain Clothes Constable Colquhoun. Without drawing this inference it is almost impossible to conceive why Mr Coleman was otherwise carrying a small vial of strychnine on his person simply by chance when he was arrested and taken into custody at about 9.10am that day.

Although Ms Ashby indicated after his death that Mr Coleman had previously referred to strychnine in the context of self harm, there was no evidence this information was known to the police prior to his final incarceration.

Mr Coleman was cooperative and resigned when taken to the watchhouse by officers Sutton and Colquhoun. There was apparently no mention of his medication before he left the farm. There was nothing to raise the officer's suspicion of a risk of self harm although with hindsight their accounts of him being talkative during the drive but then becoming suddenly drowsy, almost at the point of collapse, on arrival at the watch house, might have raised suspicion. Officer Coloquhoun accepted Mr Coleman's explanation this was due to his medication and Mr Coleman's assurance he did not require medical attention.

A pat down search was conducted by Plain Clothes Constable Colquhoun. The search was performed in the cell while Mr Coleman was in a seated position due to his drowsy condition. Mr Coleman's socks were left on although Officer Coloquhorn considered his search would have located

anything concealed in the upper part of his socks. He conceded the possibility of the small vial perhaps remaining concealed in the sole of the sock or between the toes.

Officer Coloquhorn failed to ask the required questions about medical and psychiatric conditions at the time of his admission to the watchhouse. He explained this was due to Mr Coleman's appearance of extreme tiredness, which Mr Coleman explained was a side effect of his medication. He did not return to this task later explaining the failure was due to driving the other officer back to Nanango before returning to other duties which then claimed his attention. He did not delegate the task to anyone else and said he then forgot about his responsibility until the next morning when he completed the computer custody register at about 5.30am.

Later on 16 January Mr Coleman was transported to appear before the Magistrate in Cherbourg. He was remanded in custody to appear before the Kingaroy Court on 18 January. He was then transported back to the Murgon watchhouse where he remained until transported to Kingaroy watchhouse for court on 18 January.

In the early morning of 17 January his medication, which included anti depressants, was delivered to Murgon watchhouse. The overall impression of police at Murgon was Mr Coleman was quiet and cooperative. He spent a lot of time sleeping and he tried to initiate a phone call to Rita Ashby which was rightly refused. The watchhouse keeper helpfully considered he may be assisted by accessing counselling via Mensline and this was arranged. The phone counsellor recalled Mr Coleman being passive and open to suggestion and requiring practical assistance to access legal representation as his lawyer was away. The counsellor did not pick up any suggestion Mr Coleman was considering self harm.

At about noon that day two Child Safety Officers attended the Murgon police station and asked to speak with Mr Coleman. They indicated it was necessary because Mr Coleman's children had been returned early to their mother during the current contact visit with their father. This was due to concerns for their safety. The officer in charge, Sergeant Ashley considered whether or not it was appropriate for Mr Coleman to receive such a visit given his apparent depression, but was persuaded it was necessary to inform him of these changed arrangements. Although one of the Child Safety Officers subsequently told the inquest she was concerned for Mr Coleman's welfare, this was not communicated to the police in a way that identified a risk of suicide. She also had recorded in her notes an earlier communication with Plain Clothes Constable Colquhoun who had made a reference to Mr Coleman being at risk of self harm. When pressed on this point at inquest, Officer Colquhoun stated he was more concerned, and rightly so, for Ms Ashby's welfare.

The next morning on 18 January Mr Coleman was returned to the Kingaroy watchhouse to appear in court there. He was seen initially by his solicitor Mr Murdoch at the Kingaroy police station and then again at the court house. Mr Murdoch, did not pick up any suggestion Mr Coleman was considering self harm. He was, however, concerned Mr Coleman did not seem capable of comprehending his situation before the court. He left him in the custody of a police officer while he went downstairs to make arrangement for the mental health counsellor to see him later that day as Mr Coleman was scheduled to see Mr Pledger sometime on 18 January. During his absence Mr Coleman asked the police officer whether he could speak with Rita Ashby who was seated outside. As this was in breach of bail conditions the request was refused.

Mr Coleman returned to court where submissions were made but the decision was reached to remand him in custody until 15 February 2007. Mr Coleman again tried to initiate contact with Ms Ashby while in the courtroom and this was refused by the Magistrate.

He was returned to the Kingaroy watchhouse.

A short time later, at about 2.55pm he activated the intercom buzzer. Senior Constable McCullough attended the cell and saw Mr Coleman through the upper perspex door into the exercise yard. Mr Coleman told him he had taken strychnine. The officer recognised the name of a poison and was initially incredulous and asked him where he got it from. Mr Coleman raised his hand revealing a small vial with a pink substance in it, saying he had it with him the whole time he had been in custody. He turned away and went into the open cell. Senior Constable McCullough ran back a short distance to obtain the keys and yelled out for assistance form other officers alerting them to the situation.

On his return he located Mr Coleman in the middle cell seated on the mattress with the vial up to his lips.

It was immediately taken away from him and he was strip searched to check for any other items of concern. Nothing was found. He was questioned and Mr Coleman told him he had concealed the vial in his sock and he wanted to die. He said he had drunk water and that there was enough poison to kill 150 dogs.

Although an ambulance had been immediately called a decision was made that it would be quicker to transport Mr Coleman directly to the hospital by police vehicle. This was done with all due haste and the ‘Crewman’ van entered the rear entrance of the hospital to approach the emergency entry. I accept there was nothing untoward in the police management of this situation in these circumstances, particularly when Mr Coleman was initially reluctant to get out of the van.

Treatment at Kingaroy Hospital and independent review of medical treatment

On arrival at Kingaroy Hospital Mr Coleman was attended to by Dr Kylie Burns. Hospital records indicate this was at 3:10pm.

Mr Coleman did not suffer any symptoms for the next 10 minutes. Initially he denied ingesting strychnine; instead he told Dr Burns he had taken a little bit of pink powder used to treat stock. It appears that Senior Constable McCullough suggested to Mr Coleman, perhaps out of hope more than anything, that the substance was 'pink-eye' powder. Mr Coleman adopted this suggestion.

A local veterinarian was contacted and a suggestion was made that the substance may have been an antibiotic (tetracycline).

At 3:20pm Mr Coleman suffered a seizure which lasted for approximately two minutes. Dr Burns had been on the phone to the poisons hotline and was called back to attend to Mr Coleman. An intravenous drip was inserted with the assistance of another doctor.

It was only after Mr Coleman had developed symptoms which were consistent with strychnine poisoning that he confirmed it was strychnine he had taken.

At about 3:35pm Mr Coleman suffered a small episode of muscle seizures but was still able to talk. Dr Burns again spoke with the poisons hotline, however, was called back when Mr Coleman became cyanosed with a rapid heart rate, rapid respirations and poor oxygen saturation in the blood.

Treatment was administered in the form of intravenous diazepam from 3:40pm to 3:45pm, which made it easier to get oxygen into Mr Coleman's lungs. Despite this, at 3:55pm, his heart began to slow and his pupils became fixed and dilated. Atropine was administered in an attempt to speed the beat of the heart but it had no effect.

Mr Coleman suffered cardiac arrest at 4:00pm and cardiopulmonary resuscitation commenced. Three separate injections of adrenaline were given. At this time results of a blood test taken on arrival became available. This revealed acidosis so sodium bicarbonate was administered. Cardiopulmonary resuscitation was continued for twenty minutes with no response and Mr Coleman was pronounced dead by Dr Burns at 4:20pm.

An analysis of Mr Coleman's medical records was later conducted by Dr Don Buchanan, a Forensic Medical Officer with the Clinical Forensic Medicine Unit. Dr Buchanan helpfully summarised the usual effect of strychnine ingestion in that report:

> *"Strychnine has been used for centuries as a poison to exterminate vermin. It is rapidly absorbed from the gastrointestinal tract, and is a potent central nervous system stimulant and convulsant. It produced excitation for the spinal cord and brain stem. This produces seizures with the patient conscious. These seizures can cause muscle damage and acidosis. Benzodiazepines such as diazepam (eg Valium) assist with treating such seizures. Activated charcoal can be given orally if possible to bind any strychnine that may be still present in the stomach."*

I accept Dr Buchanan's opinion that in all the circumstances treatment was timely, appropriate and reasonable. Any delay in commencement of treatment was due to Mr Coleman deliberately providing false information before ultimately admitting to Dr Burns that it was strychnine he had taken because he wanted to die. Given the evidence from both Dr Buchanan and Dr Ong regarding the concentration of strychnine consumed I am satisfied Mr Coleman had taken a fatal dose irrespective of any treatment provided to support him. There is no antidote for strychnine poisoning.

The investigation findings

The investigating officer concluded that when he was arrested on 16 January 2007 Mr Coleman was carrying a small vial of strychnine on his person. Despite being searched on two occasions by police officers later that day, this vial was not found. After attending court on 18 January 2007 and being refused bail, Mr Coleman was returned to his cell at 2:55pm and, shortly after, voluntarily ingested the strychnine. The efforts of police and medical personnel at the Kingaroy Hospital were futile and Mr Coleman died as a direct result of the ingestion of strychnine less than 90 minutes later.

The investigation found that Mr Coleman was in a relationship with Rita Lucille Ashby which involved ongoing and escalating domestic violence. The investigation revealed that Mr Coleman had expressed an intention to commit suicide on previous occasions. His personal circumstances were a source of stress and he had been prescribed anti-depressant medication and was receiving counselling.

No evidence supported a conclusion that Mr Coleman had accessed the strychnine he ultimately ingested at any time after his arrest on 16 January 2007. There was no evidence to suggest that anything other than the ingestion of strychnine had caused Mr Coleman's death.

Forensic testing was able to show that the strychnine in the vial was likely to be from the same batch found on Mr Coleman's property after his death; although could not be more precise than that. The strychnine permit found at Mr Coleman's property was issued to him pursuant to the *Health (Drugs and*

Poisons) Regulations 1996. It was found to have expired on 13 August 2006 and was not renewed.

A sample taken from the top of the vial revealed DNA matching that of Mr Coleman. A swab taken from the lid of the vial was unable to assist in determining whether the vial may have been secreted by Mr Coleman internally; in particular via the anal passage. The court heard further in relation to this matter from Dr Tim Robertson of Queensland Health Pathology and Scientific Services at the Royal Brisbane Hospital. Dr Robertson confirmed that the 'annucleated squamous cells, debris and bacteria' found on the swab may have originated from many different parts of the body; both internal and external.

Testing of other swabs taken from the cell at Kingaroy revealed the presence of strychnine on the bench/bed in the cell in which Mr Coleman had been seen sitting earlier in the day. No strychnine was found on other swabs; including those taken from Mr Coleman's socks.

Urine testing of police involved with Mr Coleman did not reveal the presence of any illegal drugs or anything else of significance.

The investigation found that there had been non compliance with QPS policies relating to search procedure and record keeping. This will be addressed later in these findings.

The autopsy

On the morning of 19 January 2007 an autopsy examination was carried out on the body of Mr Coleman by Dr Beng Ong, an experienced forensic pathologist.

Dr Ong detected no significant pathology that could account for death. No significant injuries were detected other than bruises on the front and back of the left forearm near the wrist (although these were not visible externally).
The body was otherwise only notable as a result of congestion to the face and internal organs.

Blood and urine samples were taken and toxicology testing conducted. This revealed the presence of a toxic level of strychnine being a concentration of 2.1mg/kg. In his evidence at the inquest Dr Ong indicated this was more than four times the level of .5mg / kg which was known to be fatal. He confirmed the description of Mr Coleman's clinical presentation at Kingaroy Hospital was consistent with the expected effects of strychnine toxicity, in particular the muscular spasms and convulsions leading to respiratory and cardiac arrest and ultimately, death.

Dr Ong issued an autopsy certificate on 6 March 2007 listing the cause of death as:

1(a) Strychnine toxicity

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 and circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by witnesses at the inquest 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 Randall John Coleman.

Place of death: He died at Kingaroy Hospital in Kingaroy, Queensland.

Date of death: Mr Coleman died on 18 January 2007.

How Mr Coleman Died: Mr Coleman died after deliberately and knowingly ingesting a quantity of strychnine on 18 January 2007 while in custody at the Kingaroy watchhouse. He had secreted the poison in a vial on his person in some unknown manner at the time he was arrested and taken into custody on 16 January 2007.

On 18 January, shortly after being remanded back into custody, he informed police he had taken strychnine and wanted to die. Upon admission to hospital he delayed treatment by denying he had taken strychnine and adopting a false position he had consumed a veterinary powder known as pink eye powder. This product was assumed to be the antibiotic, tetracycline. When he developed symptoms consistent with the known effects caused by strychnine poisoning, Mr Coleman admitted he had deliberately ingested strychnine, wanting to die.

The Cause of Death: Strychnine toxicity.

Concerns, comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

QPS Watchhouse procedures

Searching of Prisoners

I accept that on each occasion when Mr Coleman was taken into custody it was appropriate for police to perform a pat down search rather than any more invasive process. Mr Coleman's presentation and history did not justify a personal search, or much less a body cavity inspection.

This inquest has been unable to resolve exactly how Mr Coleman managed to conceal the vial of strychnine and secrete it into custody when he was arrested on 16 January 2007, but it is certain there was not even a remote possibility of Mr Coleman accessing the strychnine by any means other than his own action in bringing it into custody at the time of his arrest.

Mr Coleman's told Senior Constable McCullouch he had hidden the vial in his sock, but whether this is true, or whether this was simply the place in which the vial was concealed after his arrest is undetermined. The evidence from the police officers who performed pat down searches indicated they doubted they could have missed even a small vial in the upper part of his socks although there was perhaps a concession it could have somehow been concealed in the sole of his sock or between his toes as the socks were not removed during the searches.

Although it must be the case that the searches failed to discover the vial, this may not be a significant criticism when it is accepted the vial may have been concealed internally at the time of such searches.

Maintaining Watchhouse registers and associated records

Plain Clothes Constable Colquhoun explained his failure to complete the health medication and personal details form when he placed Mr Coleman in custody at Kingaroy on 16 January. It was explained that Mr Coleman was extremely tired due to the side effects of his medication and Officer Coloquhoun checked whether Mr Coleman needed a doctor, which was declined. It remains a concern that Officer Colquhoun left the station to return Senior Constable Sutton to Nanango without delegating the task of completing the health form to another officer, particularly when his evidence indicated Mr Coleman was affected by medication. This is in the context of the Kingaroy police station not having a designated watchhouse keeper but

instead it being a shared responsibility of all general duties officers to monitor prisoners in the cells.

I note in this regard the additional burden and responsibility of officers working at Kingaroy police station which does not have a designated watchhouse keeper. While it was explained that the overall numbers do not justify a change it was pointed out that during the four circuits of the District Court to Kingaroy each year, the demands to manage an increased number of prisoners are onerous. I commend the prioritisation of a new Kingaroy police and watchhouse facility which the inquest heard is now coming towards the top of the queue awaiting funding to proceed.

Assessment of risk of self harm whilst in custody

In hindsight, knowing Mr Coleman successfully executed a plan to conceal strychnine on his person and take it into custody with him, it is clear he was not only contemplating suicide but had formulated and actioned a plan to achieve his own death. Indeed his actions demonstrate his single minded determination to end his life despite initial declarations that he only wanted to gain police attention so he could see Rita again. In particular, his actions at the hospital in denying that it was strychnine he had taken and forestalling the commencement of treatment demonstrate his commitment to execute his plan.

Given this resolution and determination to conceal his intention it is hard to know what else might have saved Mr Coleman from his death.

The inquest did not receive expert psychiatric evidence and I preface the following comments that my remarks are based solely from experience as a coroner over seven years. One of the purposes of the health, medication and personal questionnaire is to identify circumstances which could indicate an elevated risk of self harm. The problem that revealed itself in Mr Coleman's case was that he was in and out of custody and transferred between watchhouses at Kingaroy and Murgon on numerous occasions over a three week period immediately prior to his death. This was a new and frightening experience for him which can sometimes perhaps be overlooked by those inured to the shock of incarceration. It was expressed that perhaps it was excessive to expect completion of the assessment form on each occasion he was moved between watchhouses. Perhaps nothing different would have been recorded or admitted to by Mr Coleman anyway.

The question that might be asked is how can police recognise when a prisoner has increased his susceptibility to suicide with the addition of more stressors which might be critical in tipping the balance?

In Mr Coleman's situation it might be assumed he would not have taken the strychnine if bail had been granted, but one wonders in retrospect whether the additional stress and disappointment when told of the removal of his children

added to the risk. While it is unrealistic to expect police officers to identify a risk of suicide during police incarceration, perhaps a heightened awareness of risk should be considered when bail is refused. Certainly Department of Corrective Service facilities automatically assesses all new prisoners and conducts assessments for risk of suicide. While this is beyond the scope of direct police training and responsibility there are other appropriate experts who could perform this task.

I acknowledge that even if such an enhanced process was in place in Mr Coleman's case, it is unlikely such intervention could have prevented his suicide.

Treatment by police and medical personnel once poisoning became apparent

I accept that once Mr Coleman's ingestion of strychnine was bought to the attention of Senior Constable McCullough, police acted promptly and appropriately.

The decision to drive Mr Coleman to hospital rather than wait for an ambulance was not only appropriate but entirely prudent. The anonymous complaint made to the CMC concerning the manner in which police treated Mr Coleman in the hospital carpark was explored at the inquest. I accept that police would have been focussed entirely on getting Mr Coleman into hospital as soon as possible. I also accept that Mr Coleman may have been reluctant or at least showing less urgency than the situation warranted.

The officers have made it clear that they dragged Mr Coleman by the leg to remove him from the vehicle. This is a method almost necessitated by the design of the 'pod' on the Holden Crewman which was being used (and which I have had the opportunity to inspect). I accept that Mr Coleman was handcuffed with his hands in front of his body and to that extent the complaint (which has Mr Coleman handcuffed from behind) is inaccurate. It is clear that the entirely appropriate haste of the officers in the circumstances could have been mistaken for 'rough' treatment. Clearly the officers were entitled to 'cajole' Mr Coleman in a manner which would not be necessary or justified in most other situations.

The only forensic evidence which might be relevant to the complaint is that of bruising on Mr Coleman's wrists. This may have been caused, though, at any time over the preceeding days. Of more significance perhaps is that no other injuries were found despite a careful forensic examination of Mr Coleman's body. I am satisfied that Mr Coleman was treated appropriately during his transport from the Kingaroy watchhouse to the Kingaroy Hospital. This would be consistent with the compassionate manner in which Mr Coleman had been dealt by police in the weeks leading up to 18 January 2007.

When he was interviewed, Senior Constable McCullough raised concerns that medical staff at Kingaroy Hospital had not attended to Mr Coleman as expeditiously as he thought necessary. This was not something he raised with any vigour at the inquest. In the interim, and as noted earlier, a report was commissioned from Dr Don Buchanan.

Dr Buchanan was supplied with all relevant medical records and transcripts of interviews with medical personnel. Subsequent to considering that material Dr Buchanan expressed the following opinion:

> *"It is difficult to see what more could have been done within this time frame. Time was taken up trying to identify the substance and making a diagnosis initially. Attempts to obtain advice about strychnine poisoning were interrupted by the patient beginning to deteriorate. Once it became clear that it was in fact strychnine poisoning, specific treatment was provided however the patient nevertheless succumbed. Given the circumstances, the timeliness and appropriateness of the medical treatment in my opinion was reasonable."*

As can be seen, Dr Buchanan relied on evidence to the effect that Mr Coleman initially denied to medical staff at the hospital that the substance he had ingested was in fact strychnine. There is no basis on which this evidence would be rejected. It may have been that Mr Coleman was deliberately trying to prevent any effective treatment being afforded to him (as he later suggested). Whatever the reason, I accept that any initial delay in treatment was the result of Mr Coleman's denial and I therefore adapt Dr Buchanan's views as to the medical treatment afforded to Mr Coleman at Kingaroy Hospital.

Conclusion

An inquest is a very public examination of what is usually expected to be the most private occasion of a person's death. Where the death is a death in custody there is added scrutiny which is distressing to family and friends of the deceased as well as to the officers who were in contact with the person during his incarceration. It is necessary though to provide assurances that no-one else was involved in his death and perhaps provide comments which might help prevent such death occurring in the future.

Mr Coleman was struggling in his personal life and was subject to an increasing burden of stressors. He had been recently diagnosed with depression and was taking mediation and receiving counselling. His personal problems worsened when he was unable to control his anger and repeatedly caused fear and injury to his partner Rita Ashby. This brought him into contact with police and the courts and ultimately into custody. It is clear that despite his final decision to end his life Mr Coleman remained devoted to Rita Ashby, and she to him.

I conclude that all efforts were made to save Mr Coleman from his deliberate ingestion of strychnine, but tragically it was futile.

I thank all those who have contributed to the investigation and process of inquest into Mr Coleman's death and now close the inquest

Chris Clements
Acting State Coroner
Kingaroy
10 July 2009