OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert Gary MITCHELL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 3772/08(0)
DELIVERED ON:	20 January 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 April 2010 & 11 May 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: death in custody, suicide, hanging points**

REPRESENTATION:

Counsel Assisting:	Ms Julie Sharp
GEO Group Australia Pty Ltd:	Mr Sandy Horneman-Wren (instructed by Blake Dawson Lawyers)
Department of Community Safety:	Ms Kay Philipson

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The *Coroners Act* 2003 provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Robert Gary Mitchell. 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

At the time of his death, Robert Mitchell was an inmate of the Arthur Gorrie Correctional Centre (AGCC). He had been on remand for a number of offences since 16 April 2008, and he was housed in Secure Unit B2 from 22 April 2008.

On Wednesday 9 July 2008, during a head count conducted just before midnight, Corrective Services Officer (CSO) Nigel Wenck found Mr Mitchell hanging in his cell. He raised the alarm and other officers and nursing staff attended. Medical attention was administered to Mr Mitchell but he was unable to be revived. Paramedics declared his life extinct at 12:32pm on 10 July 2008.

These findings:

- confirm the identity of the deceased, how, where and when he died and the medical cause of his death;

- determine whether the prison authorities should have been alerted to Mr Mitchell being at risk of self harm; and

- consider whether any changes to the prison and/or the operators policies and procedures might reduce the likelihood of similar deaths occurring in the future.

The investigation

Correctional centre staff notified the Corrective Services Investigation Unit (CSIU) of Mr Mitchell's death at about 12:45am on 10 July 2008. The CSIU is a specialist squad within the Queensland Police Service (QPS) that investigates incidents within correctional centres. Detective Sergeant Pascoe of the CSIU attended the AGCC and conducted an examination of the scene. Senior Constable Blumson, a photographic officer, assisted in that examination. The officers found no evidence of forced entry, disruption or physical altercation in Mr Mitchell's cell.

Officer Blumson took photographs and statements were obtained from various CSO's. Detective Sergeant Pascoe interviewed all of the prisoners housed in unit B2 at the relevant time and seized various prison records relating to Mr Mitchell and to movement in and around the prison on the day/night preceding Mr Mitchell's death.

Dr Olumbe conducted a post-mortem examination on 11 July 2008.

A report was prepared by investigators appointed by the Acting Chief Inspector, Queensland Corrective Service (QCS), Virginia Simmons and Senior Queensland Corrective Services investigators, Stephen Green and Roberta Embry. Those investigators are to be commended for their inquiry and report which has been of significant assistance.

The Office of the State Coroner has made further inquiries relating to injuries noted by Dr Olumbe on post-mortem examination.

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 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-inquest conference was held in Brisbane on 16 April 2010. Ms Sharp was appointed Counsel Assisting. Leave to appear was granted to the Department of Community Safety and the operators of AGCC, GEO Group Australia Pty Ltd.

The inquest was held on 11 May 2010. It was adjourned to allow counsel assisting to conduct further enquiries. Upon receipt of those enquiries I determined that no further oral evidence was required. In total nine witnesses were heard from and 68 exhibits were tendered. Mr Mitchell's family liaised with counsel assisting throughout the inquest.

I take this opportunity to express my condolences to Mr Mitchell’s family and friends.

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.

Initial risk screening

On 16 April 2008, Mr Mitchell signed a ‘Health Questionnaire and Observation Checklist’ denying any psychiatric history, including self-harm and suicidal ideation.

Mr Mitchell was assessed according to AGCC policy and procedure on reception into the centre on 22 April 2008. The records in evidence show there was no indication of a propensity to self-harm. Mr Mitchell denied he

was entertaining thoughts of suicide, and there was no information to suggest he had ever attempted suicide before. Registered Nurse, Helen Hargreaves, noted Mr Mitchell's presentation, mood and manner at that time were normal to his situation.

It is noteworthy the 'Reception Medical History', which appears to have been completed by Ms Hargreaves on 22 April 2008, is contradictory as to Mr Mitchell's mental health history. That document includes a list of questions relating to mental health issues, namely –

- Have you ever had emotional or psychiatric problems?
- Do you have a history of emotional or psychiatric problems?
- Have you ever cut, slashed or harmed yourself on purpose?
- Have you ever tried to commit suicide?
- Is the thought of ending your life on your mind?
- Do you have a history of alcohol, drug or tobacco use?

The questions appear first at page 2 of the document where all are answered in the negative. The questions are repeated on page 5 of the same document, and are all answered in the affirmative. Nurse Hargreaves suggested this was the result of a problem with the electronic form defaulting to positive answers if the file was not saved correctly. I accept the assurance made on behalf of the centre operators that this problem has been resolved.

I also accept that authorities were not forewarned by that initial assessment of any risk of self harm by Mr Mitchell. There was no reason for him to have been categorised as an 'at risk' prisoner and placed on observation, and/or housed elsewhere than in B2.

A further medical review was undertaken on 29 April 2008. The progress notes report that Mr Mitchell complained of occasional pain in his right knee and requested a bandage. Other than that, no health complaints were made.

Events of 9 July 2008

All of the inmates housed in unit B2 were interviewed by Detective Sergeant Pascoe however the only person who could give any information about Mr Mitchell's mood and behaviour on the day preceding his death was William Scriven. Mr Scriven said he had come to know Mr Mitchell during the two weeks he had been housed in B2 prior to the death. The two were not close.

At about 3:30pm on 9 July, Mr Scriven had a conversation with Mr Mitchell during which he expressed some anxiety about his legal proceedings, and general dissatisfaction with prison life. Mr Scriven talked about his recently dislocated wrist and Mr Mitchell spoke about his family. Mr Scriven was not left with the impression Mr Mitchell was suicidally depressed about his situation rather that he was unsurprisingly 'down' given his circumstances.

Other evidence before me reveals Mr Mitchell's matter was to be mentioned in the Magistrates Court on 10 July 2008, the day of his death, and it is likely this

was weighing heavily on his mind. QSC investigators noted that although Mr Mitchell's appearance had been excused, he might not have known that.

Mr Fulcher, CSO, gave evidence that on the night in question he was working as a "night rover" and he conducted a welfare check on Mr Mitchell at 7:57pm on 9 July 2008. That was part of the routine 'head count' procedure that is to take place at least every three hours according to GEO procedure. Mr Fulcher looked into cell 13 and did not notice anything out of the ordinary. Mr Mitchell was then lying down in his bed.

The death is discovered

Officers Nigel Wenck, Greg Anderson and Brian Paul conducted the subsequent 'head count' in unit B2. At 11:54pm, almost four hours after the previous count, Mr Wenck looked into Mr Mitchell's cell and immediately saw he was hanging by a ligature around his neck that was tied to the exposed bars above the cell door. Mr Mitchell appeared to be blue and his tongue was protruding from his mouth. Mr Wenck immediately called the Centre Emergency Response Team (CERT).

There was some delay in releasing Mr Mitchell from the noose in order to commence CPR.

Stuart Anderson was the Area Manager on duty. When he received the emergency call he was in W1, an observation unit. Mr Anderson could not immediately leave that unit because of movement elsewhere in the centre.

As a consequence officers Wenck and Greg Anderson were awaiting his arrival to open the door to the cell. AGCC (GEO) policy dictated that a manager had to be present before the cell could be opened and four officers are required to be in the unit. Stuart Anderson said when he arrived in B2, five minutes after the CERT call Nigel Wenck was standing near the stairs leading to the upper level and Gregory Anderson was near the fishbowl, along with another officer Brian Paul. In some cases such a delay could be fatal, although for reasons that will become obvious it had no impact on the outcome in this case. I accept the submission made on behalf of the centre operators that its policy has been revised to ensure it aligns with QCS requirements which would reduce the delay in officers gaining access to cells in an emergency.

Stuart Anderson directed Greg Anderson to open the cell door. Both men lifted Mr Mitchell while Mr Wenck used a cut-down knife to release him. CPR was commenced by the officers once he had been laid on the floor outside his cell. By that time nursing staff had arrived.

Nurses Behrends and Luffman conducted an examination of Mr Mitchell and found no signs of life. His pupils were fixed and dilated, his tongue was swollen and purple, his extremities were cold but there remained some central warmth. The nurses could not detect any peripheral or carotid pulse. They observed a one centimeter deep ligature mark around Mr Mitchell's neck. It was apparent he had been dead for some time.

Resuscitation attempts, including with the aid of a defibrillator, continued and QAS paramedics Latham and Bell arrived to assist at 12:16am. A further crew of paramedics came at 12:22am. Adrenalin, atropine and sodium bicarbonate (along with a compound of sodium lactate) were administered to no effect. Mr Mitchell's vital signs remained unchanged, and inconsistent with life throughout the efforts to resuscitate him.

As I have already mentioned, paramedics declared life extinct at 12:32am.

The investigation detailed earlier then commenced.

Autopsy evidence

Dr Olumbe performed an autopsy on 11 July 2008 and found Mr Mitchell died by hanging. Dr Olumbe observed injuries consistent with that cause of death, including a ligature mark and a fracture dislocation of part of the laryngeal skeleton (the right superior thyroid cartilage) which was accompanied by bleeding.

I have previously mentioned that Dr Olumbe noted linear marks on Mr Mitchell's wrist which were said to be consistent with self-harm. No one who had contact with Mr Mitchell the day before he died, or on the night of his death noticed the marks.

Dr Olumbe described them as "*clusters of recent superficial linear marks in the front of the left wrist*". Dr Olumbe opined that those marks were "*consistent with self infliction/harm and commonly associated with suicidal ideation*". Dr Olumbe's opinion was they must have been inflicted within a few days of the death.

Other investigation results

Notes left by Mr Mitchell extend to eight handwritten pages. They would have taken Mr Mitchell some considerable time to complete and show he had given much thought to his plan to end his life. The notes also provide insight into Mr Mitchell's internal anguish.

Findings required by s45

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his 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 other particulars of the death.

Identity of the deceased: The deceased person was Robert Gary Mitchell

How he died: Mr Mitchell took his own life while a prisoner in the Arthur Gorrie Correctional Centre

Place of death:	He died in cell 13 of the B2 secure unit at the Arthur Gorrie Correctional Centre, Queensland
Date of death:	Mr Mitchell died on 9 July 2008
Cause of death:	He died from self-inflicted hanging

Concerns, comments and recommendations

Section 46 provides that a Coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. That requires the Coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

I have mentioned a number of matters that could impact on prisoner safety that have already been addressed by the AGCC operators – accordingly no further comment is needed in relation to those issues.

Once again the primary risk factor highlighted by this case is one that has been well known and subject of public debate and coronial comment for at least 20 years, namely the existence of hanging points in prison cells.

As this case demonstrates, it is impossible to identify with precision those prisoners who might take their own lives. Of the 552 suicides that have occurred in Australian jails since 1980, 90% have been hangings.[1] Therefore, if jail suicides are to be minimized, it is essential all prisoners are kept in cells that do not have hanging points.

I accept the submission the QCS is committed to a policy of replacing unsafe cells with suicide resistant facilities as funds allow. I also accept that many unsafe cells have been closed or refurbished. Nevertheless, hundreds of prisoners remain housed in cells with exposed hanging points, despite the Royal Commission into Aboriginal Deaths in Custody recommending 20 years ago that this not occur and the State Government's public commitment to implementing the recommendation. As a result a further five prisoners have hung themselves in Queensland correctional centres since Mr Mitchell's death.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
20 January 2012

[1] AIC, Death in custody in Australia, monitoring report no. 10