QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Frederick Arthur James Row Row**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2016/3509
DELIVERED ON:	23 November 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	10 March 2020, 17-18 May 2021, written submissions – June 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, Death in custody; First Nations man, hanging; suicide risk assessment, mental health services in prison.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen
Queensland Corrective Services:	Mr Peter O'Connor, Crown Law, instructed by Ms Vanessa Price
Family:	Ms Angela Taylor and Ms Kate Greenwood, ATSILS

Contents

Introduction

1. Frederick Row Row died at the age of 34 at the Capricornia Correctional Centre (CCC). Late on the morning of 24 August 2016 he was found deceased in a single cell in the prison's Detention Unit. He had formed a ligature from a sheet slung over a door between his cell and the adjoining exercise yard. The incident was captured on a CCTV camera located inside the exercise yard.

2. Mr Row Row had assaulted a fellow prisoner on 21 August 2016, causing serious injuries. He was concerned that if that person died, he faced a lengthy term in prison. He subsequently made threats of self-harm. He was initially taken to the CCC Health Centre and placed on 15 minute observations as his risk of suicide was assessed as high.

3. Two days later, on 23 August 2016, his suicide risk was assessed as low, and he was transferred to the Detention Unit where he was on 120 minute observations.

4. On the morning of 24 August 2016, Mr Row Row was observed crying in his cell. He subsequently disclosed to the assessing psychologist that he had been having "intermittent" suicidal ideation and had considered "drowning himself in the toilet." After a welfare check by the psychologist and a Cultural Liaison Officer (CLO) his risk level was maintained at low.

5. These findings confirm the identity of the deceased person, how he died, and the time, place and cause of his death. They also consider:

    i. whether the authorities charged with providing for Mr Row Row's mental health and physical care at Capricornia Correctional Centre prior to his death, adequately discharged those responsibilities;

    ii. Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances, including:

        a. the sufficiency of staffing in the Detention Unit;

        b. whether changes need to be made in how risk assessment and Risk Assessment Team (RAT) meetings are conducted;

        c. whether 'at-risk' prisoners should be housed in a more appropriate unit within the facility that allows for continuous observation and monitoring.

The investigation

6. Detective Sergeant Carr of the Corrective Services Investigation Unit (CSIU) investigated the circumstances surrounding Mr Row Row's death.

He provided a Coronial Report in June 2017 with various annexures, including witness statements and medical records.

7. The CSIU and local police from Rockhampton were advised of Mr Row Row's death at about 12:30pm on 24 August 2016. Arrangements were made for Rockhampton Police and Scenes of Crime officers to attend the CCC Detention Unit. Mr Row Row was observed lying on the floor in the doorway between Cell 5 and the exercise yard.

8. The Scenes of Crime officer recorded the scene, including fingerprint examination for identification purposes. Mr Row Row was physically examined at the scene and there appeared to be no external injuries other than recent medical intervention.

9. CSIU Detectives arrived at the CCC on the morning of 25 August 2016 and commenced the process of taking statements from staff and inmates. They took steps to seize relevant records and interrogated the Integrated Offender Management System (IOMS). Detective Sergeant Carr also arranged for statements to be obtained from senior officials at the prison. Relevant CCTV footage was seized.

10. Detective Sergeant Carr did not consider Mr Row Row's death was suspicious. He was satisfied that he was locked alone in his cell at the time and no other persons were involved.

11. In addition to the QPS CSIU investigation, the Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by the *Corrective Services Act 2006*. Those investigators prepared a detailed and thorough report which was submitted to the Office of the Chief Inspector (OCI). That report was tendered at the inquest and was of assistance in the preparation of these findings.

The inquest

12. As Mr Row Row was a prisoner detained under the *Corrective Services Act 2003* an inquest was required. A pre-inquest conference was held at Brisbane on 10 March 2020. The inquest was originally scheduled for June 2020 at Rockhampton but was delayed by Covid-19 restrictions. The inquest was held at Yeppoon on 17-19 May 2021.

13. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Leave to appear was granted to Queensland Corrective Services (QCS) and Mr Row Row's family.

14. The following witnesses were called to give evidence at the inquest:[1]

- Detective Sergeant Carr
- Troy Marschke –Custodial Correctional Officer, CCC
- Lionel Smith –Cultural Liaison Officer, CCC
- Stephanie Haddock – Acting Senior Psychologist
- John Clark – Correctional Supervisor, CCC
- Nicole McCance – Manager Offender Development, CCC
- Alexis Livingstone – Acting General Manager, CCC
- Peter Shaddock - Deputy Commissioner, Queensland Corrective Services
- Dr Samara McPhedran – expert witness.

The evidence

Personal circumstances and correctional history

15. Mr Row Row was a proud Kullili and Darumbal man. He is survived by his partner Glenda Barnes, their two daughters and many other family members. Mr Row Row had lived in Rockhampton with Ms Barnes. I extend my condolences to his extended family and friends.

16. Mr Row Row's family provided a statement at the inquest. His family said that he was the loving father of Sheanea and stepfather of Tara-Lee –

> "*he was not just a dad but a loving uncle to many, brother to many, nephew to many and a loving partner, Fred was loved by all his family and friends, he was known for his big smile and larrikin laugh. His family meant the world to him and he will always be remembered as Froggy*".

17. Ms Barnes said that she visited Mr Row Row in prison every Saturday morning. Her last visit was on 20 August 2016. She also had daily telephone contact. She said that Mr Row Row told her that he had been singled out by officers at CCC and was picked on by them emotionally.

18. Mr Row Row was close to his family and was particularly close to his brother, Dawson, who was also imprisoned at CCC. Mr Row Row was a regular cannabis user and occasional consumer of alcohol and methylamphetamine.

19. Mr Row Row was known to police from an early age. His first court appearance was at 12 years[2] and he served his first period in detention at age 16.[3]

20. His adult criminal history commenced in 2000, when he was 17 years. His offending was consistent until his final conviction on 1 July 2016. By then

[1] The roles listed refer to those occupied at the time of Mr Row Row's death. Witnesses Marschke, Smith and McCance are no longer employed by QCS.
[2] Ex C2
[3] Ex C2

Mr Row Row had been convicted of over 120 offences, consisting primarily of property, motor vehicle and domestic violence related offences.

21. Mr Row Row's criminal history also contained six convictions for violence related offences. On 1 August 2003, he was sentenced in the Rockhampton District Court to a head sentence of five years imprisonment for a single count of grievous bodily harm, one of assault occasioning bodily harm while armed, and two counts of burglary with intent to commit an indictable offence by breaking.

22. At the time of sentence, Mr Row Row had served 237 days in presentence custody. This was the most significant period of imprisonment to which Mr Row Row had been sentenced. He had spent nine different periods in Queensland Corrective Services custody,[4] having continued to offend while on parole.

23. Mr Row Row was also convicted for escaping lawful custody in 2009. He had escaped from CCC with two other prisoners after 9.00pm. He called '000' the following morning because it was daylight, and they would be late for muster. He was returned to CCC within 17 hours of his escape.[5]

Final period of custody

24. On 21 April 2016, Mr Row Row was convicted of contravening a requirement. He was sentenced to two months imprisonment and immediately released on parole. He failed to comply with the conditions of this order and an arrest warrant was issued on 26 May 2016.

25. On 25 May 2016, he had been charged with contravening a domestic violence order and possession of drug utensils. He appeared in the Rockhampton Magistrates Court on 26 May 2016 and was remanded in custody. On 27 May 2016, he was transferred to CCC where he remained until his death. His parole was indefinitely suspended on 16 June 2016.[6]

26. On 1 July 2016, Mr Row Row was sentenced to 18 months imprisonment with a parole release date of 1 December 2016, and a declaration of 11 days presentence custody. He was sentenced for one count of burglary and commit indictable offence (domestic violence offence), two counts of contravention of a domestic violence order (aggravated offence), and two counts of possessing drug utensils or pipes.

Behaviour and mental health concerns while in custody

27. When Mr Row Row was initially received into CCC he was accommodated in a double up cell with another inmate, due to operational requirements

[4] Ex C19
[5] Ex C52
[6] Ex C22

of the centre. During his incarceration at CCC he was classified as a high security prisoner.[7]

28. On 27 May 2016, he was referred to a provisional psychologist due to a self-harm episode history (SHEH) flag and several recent losses, including a family suicide in the past seven days.

29. During a risk assessment following an Initial Risk Needs Assessment (IRNA) referral, he identified historical self-harm behaviours characterised by cutting. He stated he that he had not engaged in the behaviour since his mother passed away in 2001.[8] He denied any mental health diagnosis. He also denied self-harm/suicide ideation, plans or intent and stated he would seek help if required. As his earlier self-harming behaviour was said to have occurred in 2001 it was determined that no at-risk procedures were required at the time of the assessment.[9]

30. On 20 June 2016, Mr Row Row was housed in Secure Unit 9 (S9). He yelled abuse at CCOs Brady and Webber, disrupting the order of the unit. CCOs Brady and Webber told Mr Row Row he was going to be taken to Correctional Supervisors to be interviewed about his behaviour in the unit. As they approached the S9 and S10 walkway gate, he became argumentative and swung his elbow back, hitting CCO Brady in the right cheek.[10] The CCO did not make a complaint to police about this incident.

31. Consequently, Mr Row Row was moved to the Detention Unit, Cell 7 (D7) the following day, where he remained until 27 June 2016.[11] While in the Detention Unit he had access to the adjoining exercise yard. The internal door was left open 7 to 8 hours a day.[12]

32. On 27 June 2016, Mr Row Row was moved to Secure Unit 7 (S7). At this time, he was put on an Intensive Management Plan (IMP). He complied with the conditions of his IMP without any cause for concern until an incident on 21 August 2016. Ms Livingstone told the inquest that the purpose of an IMP was to support positive behaviour change. Mr Row Row had reached stage 2 of the IMP and it was scheduled for review in September 2016.

33. He was moved to Secure Unit 6 (S6) on 4 July 2016, and he was placed in double up accommodation with another inmate due to the operational needs of CCC. He had no issues with this. When he was inducted into S6 he denied any current ideation, intent or plans for suicide or self-harm and no further at risk procedures were required.

---

[7] Ex C20

[8] Ex C5. The date of his mother's passing conflicts with what he told Psychologist Haddock on 22 August 2016

[9] Ex C5

[10] Ex E10, 7

[11] Ex C19. Moved to D7 on 21 June 2016, then moved to D2 on 24 June 2016 until 27 June 2016.

[12] Ex C5

34. Offender Case File records indicate that on 17 August 2016 another prisoner, Paul Wise, died in the unit where Mr Row Row was accommodated.[13] The prisoner was someone Mr Row Row identified as a close friend he had known in the community and in custody. A welfare check was conducted, and Mr Row Row reported that he was coping well despite the circumstances. He was provided with strategies for self-care for the next 24 – 72 hours.

35. On Sunday 21 August 2016, during a phone call to his partner, Mr Row Row believed that several inmates were 'eyeballing' him. After he ended the call, he had a physical altercation with inmate Zachary Ford.

36. Mr Row Row described having a *'brain explosion'* where he punched Mr Ford in the head several times. Mr Ford fell to the ground where he started fitting.[14] This incident occurred in the S6 exercise yard. Mr Ford was taken to the Rockhampton Hospital for treatment. He was then transferred to the Princess Alexandra Hospital as he had a fractured skull and a bleed on the brain.

Events leading up to the death

37. Because of the assault on 21 August 2016, Mr Row Row was removed from his unit. He was immediately remorseful and concerned for Mr Ford's health, fearing that he would not survive his injuries. Mr Row Row stated he was going to kill himself because he had killed Mr Ford.

38. He also said that because there had been so many deaths in his family he wanted to die too.[15] At 6.22pm, Mr Row Row was assessed as being of "high risk" of self-harm and he was taken to Medical Unit and placed in an at risk cell, on a 15 minute physical / 15 minute CCTV observation regime.[16] A temporary safety order was approved.
39. On 22 August 2016, Mr Row Row was assessed by provisional Psychologist, Stephanie Haddock. During the interview Mr Row Row was wearing a prison issued suicide gown. He cited stressors including the death of his partner's sister, a suicide attempt by a close family member on 16 August 2016, his mother's death in 2015, the conditions of his Intensive Management Plan (IMP) and a warrant for his daughter's arrest.[17]

40. Mr Row Row said that he felt a great deal of shame for the assault on Mr Ford. This shame was exacerbated by his cultural position within CCC as an older First Nations male. He confirmed he told Corrective Service Officers that if Mr Ford died, he would kill himself.

41. Ms Haddock told the inquest that she took into consideration information about the assault, the strength of Mr Row Row's family relationships, the

[13] Paul Wise was subsequently found to have died from natural causes.
[14] Ex C58
[15] Ex C6
[16] Ex C8
[17] Ex C8. Mr Row Row had disclosed at intake that his mother had passed away in 2001.

recent losses experienced by him and cultural information from Cultural Liaison Officer (CLO) Mr Smith. He was open to assistance and denied any suicidal ideation, plan or intent.

42. Mr Row Row also disclosed that he felt isolated in unit S6. At the conclusion of her risk assessment, Ms Haddock determined that on the balance of risk and protective factors, his observations could be reduced from the high level to a medium "at-risk" level, which required 60 minute physical and 60 minute CCTV observations. She also liaised with Mr Smith during this assessment to ensure that Mr Row Row's cultural needs were being met.[18] She said the policy at CCC was that prisoners are maintained in safer cells while on 60 minute observations.

43. Ms Haddock said that CLOs would generally inform psychologists about specific cultural matters of concern except for "men's business". For example, it had been indicated that Mr Row Row had reported ringing in his ears which may have related to cultural issues surrounding mourning.

44. Mr Row Row was subsequently kept in the medical unit as CCC practice was for prisoners on hourly observations to be housed in a safer cell either in that unit or the Detention Unit. The Deputy General Manager, Alexis Livingstone, approved the Safety Order to be in place from 22 August to 18 September 2016.

45. On 22 August 2016, Mr Row Row also returned a positive urine test for cannabis, buprenorphine, and methamphetamine. However, a confirmation test dated 14 September 2016 returned a clear result.

Risk Assessment Team Meeting- 23 April 2016

46. On 23 August 2016, Mr Smith conducted a risk assessment of Mr Row Row together with CLO Ethel Speedy. During the assessment he expressed more concern for Mr Ford's health than his own physical welfare. He asked Mr Smith to apologise to Mr Ford on his behalf. During this time Mr Row Row also spoke about his concerns and issues relating to his daughter and recent deaths in the family. At no time did he indicate he had any thoughts of self-harm.

47. Mr Smith told the inquest he had known Mr Row Row for around 10 years and that he was well liked. He based his risk assessment on Mr Row Row's responses to a list of questions and his body language. He also referred to case notes and the custodial supervisor. He said the assessment took around an hour.

48. Ms Speedy told OCI investigators that she told Mr Row Row that Mr Ford was "all right and was off the life support machine". Mr Ford's grandmother had called her to keep her up to date about his condition. Ms Speedy was also aware that Mr Row Row was concerned about his daughter's involvement in the Youth Justice system and his relationship with Ms

[18] Ex B6

Barnes.[19] Ms Speedy had worked in the justice system for over 30 years and had known Mr Row Row for most of his life. They were both from Darumbal country.

49. A RAT meeting was conducted at 2.00pm on 23 August 2016. As part of this meeting the panel considered a report from CLO Smith, provisional psychologist Melinda Sercombe and supervisor John Clark. CLO Smith recommended that Mr Row Row's observations be reduced to "low".

50. Mr Clark was the Correctional Supervisor with responsibility for the Health Unit. He interviewed Mr Row Row on 23 August 2016 for the purpose of the RAT. Mr Clark said that he used the risk matrix but did not have training in risk assessment. He said that he 'just wrote down the answers' and referred to recent case notes on IOMS

51. Mr Clark told the inquest that he followed the guidance of psychologists in RAT meetings as they were the experts. Mr Clark said that Mr Row Row wanted to go back to the medical unit, but he did not think that was a suitable placement as there were only two small cells for at risk prisoners. Mr Clark said that Mr Row Row was calm when he interviewed him and indicated he wanted to be with his family and friends. He also said that placement decisions were not made by the RAT in 2016.

52. Ms Sercombe noted in her report that Mr Row Row had "*internal support people at CCC, however it is noted that due to the recent incident the status of these individuals as supports is no longer secure.*"[20] She further noted under the heading "institutional problems" that *"…it is currently unclear if this assault has led to institutional issues / association issues with other prisoners."* Notwithstanding, she also recommended that his at-risk observations regime be reduced to "low".

53. The RAT was chaired by Manager Offender Development, Nicole McCance. Ms McCance had been employed by QCS for over 22 years.[21] Her role included the supervision of CLOs and psychologists.

54. The RAT ultimately determined that observations could be reduced to two hourly physical observations in appropriate accommodation. Ms McCance said that this allowed Mr Row Row to be moved from the medical unit and placed back into a unit in general accommodation. However, due to his assault on Mr Ford, he was placed in the Detention Unit, Cell D5, on a Safety Order at about 3.00pm. As Mr Row Row had seriously injured Mr Ford, there was concern for his safety if he was placed in the Secure Unit.[22]

CCC Detention Unit

[19] Ex B31
[20] Ex C9
[21] Ex B41
[22] Ex B38

55. The Detention Unit houses prisoners who have been separated from the general prison population. The unit has electronically operated doors which once locked cannot be opened by prisoners who are inside the cells. The cell doors are remotely operated by Master Control after lockdown and opened by a Central Control station located in the unit when the unit is staffed by CCOs. Supervising CCOs have a master key which can open the cells from the outside.[23]

56. Cell D5 is a solitary cell, containing a single bed, toilet and basin. The cell door faces the corridor and has a viewing window. Below the level of the viewing window and to the left of the door (when looking from the corridor) is a food hatch. D5 had a connecting enclosed exercise yard and shower and was accessed by an internal door, locked by key. The door remains locked except for periods when the prisoner can exercise.

57. The bedding issued to Mr Row Row in Cell D5 was a bottom sheet, top sheet, pillowcase, doona and pillow.[24]

58. There were two CCTV cameras fitted in the relevant areas occupied by Mr Row Row. One camera in the cell, fixed to the corner wall above the toilet and aimed generally in the direction of the cell door. The toilet and bed are clearly visible. The door and doorway which led from the cell to the exercise yard was not within camera's field of vision.[25]

59. The second camera was fixed in the exercise yard, on the far side of the exercise yard from the prisoner's cell, with a view of the internal doorway into the cell. The shower and the exercise yard were within the camera's field of vision.

Day of Mr Row Row's death

60. On 24 August 2016 there was one other prisoner housed in the Detention Unit with Mr Row Row, occupying cell D9.[26] Correctional Officer Troy Marschke was rostered to monitor the Detention Unit on his own.

61. At about 7.30am, Mr Row Row was found crying in his cell by CCO Marschke during morning muster. Mr Row Row was visibly upset and asked about Mr Ford's condition. CCO Marschke assured him that he was sure Mr Ford was fine.

62. Mr Row Row asked if he could speak with the CLO. CCO Marschke asked Mr Row Row if he was at any risk of self-harm and he said 'no'. He arranged for the CCC psychologist to attend on Mr Row Row out of concern for his welfare.

63. The psychologist, Ms Haddock, waited for CLO Smith to commence work before speaking with Mr Row Row, as she was aware there were cultural

[23] Ex A8, p3
[24] Ex A1
[25] Ex C74, p. 32.
[26] Ex C54

issues being discussed between Mr Row Row and Mr Smith. Mr Marschke said that he was preparing a Notice of Concern while Mr Smith and Ms Haddock spoke with Mr Row Row.

64. At about 8.20am, Ms Haddock and Mr Smith met with Mr Row Row in his cell. When asked how he was, he told them that he "had a bit of a cry this morning". Mr Row Row said he had a headache as he did not get much sleep the night before. He said he had been up all night "thinking about everything going on with him".

65. Mr Row Row wanted to return to the medical centre, not due to any perceived risk but because he said there were more frequent conversations with guards, and he had access to the exercise yard. Ms Haddock reassured him that he would have access to exercise time and that the psychology and CLO team could offer him any additional support. She told the inquest that it was common for prisoners to be upset and crying in their cells and wanting to move to another unit. Ms Haddock said that Mr Row Row was given assurances by Mr Smith that Mr Ford was not going to die because of the assault.

66. Mr Smith said he could arrange a meeting with Mr Row Row's brother, Dawson, and other friends who were also in custody at CCC. Mr Row Row was surprised they still wanted to talk to him and was happy that he could meet with his brother. Mr Smith also told the inquest that he often arranged phone calls for First Nations prisoners because the cost was prohibitive, and calls were an essential part of maintaining family contact.

67. During this time Ms Haddock conducted a welfare check, not as part of a formal risk assessment for the RAT. Mr Row Row denied any current self-harm ideation, plan or intent. He did disclose that he had a fleeting ideation and considered drowning himself in the toilet earlier, but denied feeling that way anymore. Ms Haddock and Mr Smith reassured him about the support systems available and that they could return to see him at any time. Ms Haddock thought that Mr Row Row's regime of two hourly observations was appropriate.[27]

68. When asked whether Mr Row Row's impulsivity was taken into account as part of the risk assessment, Ms Haddock said that he was on an IMP which was indicative of poor behaviour and therefore a relevant risk consideration.

69. After this meeting Mr Row Row asked to make a phone call and use the exercise yard. CCO Marschke informed him that he did not have the paperwork in relation to whether the exercise yard could be left open. He advised Mr Row Row he would get that information and return. Mr Marschke told the inquest that the door was a known hanging point and he withheld access until he saw the paperwork.

[27] Ex B6

70. At about 9.30am, CCO Marschke obtained the Safety Order and 'At Risk Instructions' for Mr Row Row. He took the phone to Mr Row Row and opened the exercise yard by unlocking the internal door.

71. Mr Row Row phoned his partner, Glenda Barnes. The call was abruptly cut off due to time expiring at 9.58 minutes. During the phone call Mr Row Row was audibly upset. He was crying and told Ms Barnes of his concerns about Mr Ford's condition. He said he was worried Mr Ford might die and he would receive a life sentence.

72. Ms Barnes attempted to placate him, reassuring him Mr Ford was not on life support and that was a good sign. She also told Mr Row Row that she would always support him. Just before the phone call ended Mr Row Row was still crying and said "…*don't go ringing any coppers on me or nothing, my fucking life is on the line*".[28] This was the last time Mr Row Row and Ms Barnes spoke.

73. After the call, Mr Row Row thanked CCO Marschke for allowing him the phone call. He then asked if he could make another call but CCO Marschke said he was not allowed to make consecutive phone calls and would have to wait.

74. Mr Row Row seemed content with this and asked for a Bible. Mr Marschke told the inquest that his mood was better after the phone call and he had stopped crying. It was not unusual for prisoners to request a Bible as this was the only reading material available in the Detention Unit. He had around five interactions with Mr Row Row over the course of the morning and his mood had improved considerably.

75. From the available CCTV footage timestamped as commencing at 11.15am, the exercise yard door was open. There was a white sheet or towel draped over the top of it. Mr Row Row's shirt was hanging off the handle on the back of the door.

76. At about 11.20am CCO Marschke provided Mr Row Row with a second phone call to his partner but it went to voicemail. The internal door to the exercise yard and shower remained opened. At both times CCO Marschke allowed Mr Row Row a phone call, he passed him the phone through the meal hatch of the cell.

77. At about 11.30am CCO Marschke left the Detention Unit to collect the meal trolley from the kitchen. This was the last time he recorded in the observation log as sighting Mr Row Row.[29] The two prisoners in the Detention Unit were left unsupervised apart from CCTV observations from another unit.

78. At 11.33am, Mr Row Row took the bedsheet, folded it in half and put the two ends of the sheet over the internal door to the exercise yard, just above the top hinge. He twisted the sheet several times creating a loop.

[28] Ex E1

[29] Ex C12

He put his head into the loop, put a towel over his head and held open the Bible.

79. At 11.37am, Mr Row Row, commenced his attempts to use the sheet as a ligature. At 11.38am, he stood causing the sheet to tighten. He caused his legs to go limp, placing his bodyweight into the sheet and dropped the Bible. Mr Row Row's arms remained outstretched in front of him for about 40 seconds, before they dropped by his side.

First Response

80. CCO Marschke returned to the DU at approximately 11.50am. After CCO Marschke delivered food to the other prisoner, he walked to Mr Row Row's cell and heard the shower running. He opened the latch and put the meal in the slot and called out to Mr Row Row. There was no answer, he looked into the cell and it appeared that Mr Row Row was standing in the doorway.

81. CCO Marschke realised that Mr Row Row was not moving and not responding to his name. He used his radio to call a *'Code Yellow'* (Officer requiring assistance) and a *'Code Blue'* (Medical emergency) in the Detention Unit, saying *"prisoner hanging himself".*

82. At 11.52am, he opened the cell door and confirmed Mr Row Row was hanged from the internal door in a slumped position.[30] He closed and secured the door and ran to the office to get the cut down knife.

83. The first response team arrived at approximately 11.56am and entered the cell. They found Mr Row Row hanged by the neck about two thirds up the internal door. The bed sheet was twisted, with a knot on the top hinge of the internal door.

84. CCO Bellis and CCO Goodall lifted Mr Row Row's body as CCO Marschke attempted to cut the sheet towards the top of the internal door. CCO Bellis then loosened the sheet around Mr Row Row's neck and CCO Marschke cut the sheet and Mr Row Row was placed on the floor of the cell in the recovery position. His body was limp and lifeless and there was vomit in his mouth.[31]

85. The CCOs then rolled him over and began chest compressions and used a face shield to supply breaths. The first response team took turns applying CPR. CCC Nurses then attended and started treatment, applying a defibrillation machine and oxygen. As no pulse was detected the defibrillation machine advised "no shock". CPR efforts continued and a Guedel airway was inserted. The monitor still advised "no shock" and CPR continued until Queensland Ambulance Service (QAS) arrived at approximately 12.12pm. Mr Row Row was declared life extinct at 12.15pm.[32]

[30] At least two Corrective Services Officers must be present to open and/or enter a cell

[31] Ex B2

[32] Ex C41

Autopsy results

86. An external and partial internal post-mortem examination was performed by Dr Nigel Buxton on 26 June 2016 at the Rockhampton Mortuary.[33] Toxicology testing was also undertaken.

87. The external examination revealed minimal recent injuries, with a ligature mark around Mr Row Row's neck consistent with the rolled edge of a sheet.

88. The internal examination was limited to the neck. This revealed a fresh bruise along the front of the sternocleidomastoid muscle.

89. Toxicology testing indicated that Mr Row Row had no alcohol or drugs of abuse in his system. Therapeutic levels of the anti-inflammatory drug Naproxen and Paracetamol were found.

90. Dr Buxton found that the cause of Mr Row Row's death was neck compression, by way of hanging.[34]

Investigation findings

CSIU Report

91. Detective Sergeant Carr's report[35] noted that the primary focus of a death in custody investigation was to ensure 'adequate medical care' was given to the prisoner and there are no suspicious circumstances surrounding the death.

92. Detective Sergeant Carr concluded that Mr Row Row was under the supervision of health professionals at the CCC who had recommended he be kept under 120 minute observations on the afternoon of 23 August 2016 as per the "At Risk Management Plan". There was no evidence that this had not been adhered to.

93. Detective Sergeant Carr noted that cells in the Detention Unit are designed to be a safe place to detain the prisoners. There were few physical contents, to minimise any self-harm actions by the prisoners. The connecting door between the cell and the exercise yard / shower was to be kept closed and locked unless accessed by the prisoner for a shower or exercise. In this instance, the adjoining door was left open. CCO Marschke believed Mr Row Row was taking a shower and initially had no cause for concern.

94. CCTV footage showed the preparatory steps, the subsequent hanging and discovery by Corrections Officers took place in the space of about 16 minutes. The time from the initial preparation to Mr Row Row appearing unresponsive on the CCTV was approximately three minutes.

[33] Ex A6

[34] Ex A6, page 4

[35] Ex A8

95. Detective Sergeant Carr was satisfied adequate care had been provided and there were no suspicious circumstances in relation to this death. He concluded that the death may have been avoided if the interconnecting door from the Detention Unit cell to the exercise yard/ shower had been closed, negating the hanging point that was utilised by Mr Row Row.

96. Detective Sergeant Carr concluded that there was no act or omission by any person which resulted in the death. He did identify that it appeared that Correctional staff were not rostered to be constantly present at the Detention Unit for supervision of the prisoners detained in the Unit.

97. However, he did not believe this detail would have changed the outcome in this instance as the incident occurred in a very short period. The response time may have been 'fractionally faster' which may have been beneficial to the initial medical response.

Office of the Chief Inspector Report

98. A report was prepared by the Office of the Chief Inspector (OCI) following the review of Mr Row Row's death. The findings identified in the investigation were primarily local procedural issues rather than systemic factors and were largely related to compliance with Custodial Operations Practice Directives (COPD).

99. As part of the investigation Inspectors interviewed CCC staff involved with Mr Row Row and with the management of the facility.

100. It was apparent that staff did not comply with the COPD and there was an accepted culture about leaving the exercise door open for more than two hours, without any continuous observation.

101. The OCI commented that the response to Mr Row Row's cell on the day of his death, was swift and appropriate. Medical and ambulance officers were not impeded in responding and providing assistance. [36]

Risk assessment review

102. The OCI report examined the safety review and monitoring process at CCC and how they were carried out in relation to Mr Row Row,[37] together with the COPD.

103. The OCI Report noted that the RAT meeting minutes, while described as "minutes", did not record any discussion that may have occurred among the participants of the meeting. Rather, the document:

(a) Was largely prepared in advance of the meeting.

[36] Ex C74, p. 46

[37] Ex C74, pp. 9-32

(b) *Records verbatim what each of the three report-writers recorded in their reports. This was done by the provisional psychologist to whom CLO Smith and supervisor Clark had earlier emailed electronic copies of their reports. Ms Sercombe appears to have "cut and pasted" the content of the three reports into the minutes document. Ms Sercombe (and any psychologist in her position) was therefore aware of the views of the CLO and the supervisor prior to the meeting.*

104. The OCI Report concluded that such a process carries a risk that the recommendation from a RAT meeting has been determined prior to the meeting and in the absence of discussion (meaningful or otherwise) about the prisoner's mental health and the risk of self-harm or suicide, and what steps the centre ought to take to manage that risk.

105. The OCI report made four findings with which I am in general agreement:

i. The door between Mr Row Row's cell in the Detention Unit and the exercise yard for his cell was left open, and as Mr Row Row was not under constant observation, this was contrary to the Risk Management COPD.

ii. The level of risk management Mr Row Row was placed on in the DU was not congruent with risk factors known at the time.

iii. An effective anxiety reduction strategy was not in place to reduce the anxiety level of the at-risk prisoner who was concerned about the consequences of his alleged assault of the injured prisoner (Mr Ford).

iv. A Notification of Concern (NOC) was not raised following new information relating to risk, following the Risk Assessment Team (RAT) meeting on 23 August 2016.

106. The OCI also made a total of seven (7) recommendations:

i. Consider whether handovers between General Managers should include updates to COPD and status of local implementation of COPDs that is outstanding.

ii. Staff training conducted to inform staff (or ensure staff remain aware) of the requirement of the COPD in respect of the supervision and management of 'at risk' prisoners accommodated in a Detention Unit.

iii. More effective statewide governance and oversight of COPD governance and implementation by centres.

iv. More effective local oversight of COPD requirements, including oversight of the implementation of updates and changes to COPDs,

and adequate staff briefing to ensure understanding and implementation.

v. Risk assessment reports should specifically and comprehensively outline all risk factors and an analysis of protective factors; and there should be an adequate quality assurance practice in place to ensure these risk and protective factors are documented appropriately.

vi. RAT meetings should consider and adequately document internal placement decision outcomes and rationale.

vii. Consider a practice change requiring relevant staff to implement a clear negative emotion (e.g., anxiety, shame, guilt) reduction plan for situations when there are high levels of such emotions affecting at-risk prisoners.

Changes at CCC following the OCI report

107. The OCI report noted that some changes were made by CCC immediately following Mr Row Row's death, namely:

- The CCC implemented relevant provisions of the COPD, specifically that the exercise yard door in the Detention Unit cells could only remain open with continual observation. An A4 sign was posted in the Detention Unit Officers' Station to this effect. Information as to the requirement is also contained in all Safety Orders for prisoners.

- New face masks were ordered for officers' use when performing CPR on prisoners

108. In response to the recommendations made by the OCI, the following further relevant actions have been undertaken by CCC and Queensland Corrective Services since Mr Row Row's death:

- CCC implemented a new local practice, which required the regular review of local instructions to ensure they were in accordance with the Practice Directions, including any updates or changes, and to ensure any amendment to the local processes were known and effectively distributed to staff. This process is now overseen by the CCC Local Assurance Framework Committee to ensure compliance.

- Two staff are now always rostered on within the Detention Unit at CCC.

- Pursuant to the Assurance Framework, a Local Assurance Framework was developed to ensure the governance and oversight of Practice Directions on a local level, which identified key areas of risk and the minimum requirements of oversight in relation to these risks. Biannually, Centres are required to undertake a self-evaluation of the effectiveness of their frameworks to ensure any weaknesses

in oversight areas are identified. These evaluations are also overseen at a State level.

- An email was sent to relevant 'at-risk' assessment staff at CCC reminding them to specifically and comprehensively detail within RAT reports all known risk factors and an analysis of the protective factors. This information was to then be checked and quality assured to ensure these risks and protective factors are appropriate and adequately documented by the Senior Psychologist. Further, RAT panel meetings were to consider the suitable and appropriate placement of prisoners, with the rationale documented.

Expert Review

109. Dr Samara McPhedran[38] provided a report to the Coroners Court which considered the appropriateness of the risk assessments completed for Mr Row Row, including:

    i. General overview of suicide risk assessment and risk and protective factors;
    ii. Identification of Mr Row Row's risk and protective factors and the appropriateness of risk assessments undertaken, based on those factors;
    iii. Additional issues associated with risk assessments undertaken.

110. Dr McPhedran also considered the appropriateness of the treatment provided to Mr Row Row at CCC. Dr McPhedran noted that Mr Row Row's level of suicide risk was reduced from high to low in a period of less than 48 hours. His level of risk was maintained as low on the morning of 24 August 2016.

111. Dr McPhedran indicated that risk assessment is extremely challenging, even for experienced clinicians. Suicide risk assessment is time specific, giving a snapshot of an individual at a certain moment in time. At the inquest she acknowledged that she did not have clinical experience and her focus was on research.

112. The task of assessing risk has additional unique challenges when the individual is within a correctional setting, particularly as inmates have higher rates of suicidal ideation and behaviours.[39] Dr McPhedran noted that in assessing a person's immediate risk of suicide consideration of both risk and protective factors is necessary, and relevant to determining how an individual should be managed.[40]

[38] Previously Deputy Director of the Violence Research and Prevention Program at Griffith University, and a Lecturer and Senior Research Fellow at the Australian Institute for Suicide Research and Prevention.
[39] Ex G1, pg. 7
[40] Ex G1, pg. 10 & 11

113. Having considered the appropriateness of the risk assessments conducted with respect to Mr Row Row between 21 August and 23 August, Dr McPhedran noted the following:[41]

- The static risk factors were relatively well recognised, particularly by Ms Haddock and Ms Sercombe.

- Mr Row Row was not receiving ongoing mental health support while in custody when he had a history of self-harm that was disclosed at the time of his induction.

- Mr Row Row had a history of impulsivity and aggression, which appeared to have been overlooked in the assessments conducted. Furthermore, it was noted that suicides by First Nations people can be more impulsive with fewer warning signs before the event, which is a relevant consideration.

- A majority of the relevant dynamic factors, which applied to Mr Row Row were identified during the assessments conducted in this period. The exception was the feelings of shame he was experiencing after the assault of Mr Ford and the significance of the recent bereavements he had suffered.

- Dr McPhedran noted that the death of Mr Row Row's family members seemed to feature less prominently than other considerations, particularly past deaths that he may have not self-reported but were outlined in his offender file.

- Mr Row Row's verbal disclosures around suicidality (which took the form of denying suicidal ideation) were given considerable attention during the assessments conducted between these dates.

- Most of the information relied upon to conduct the assessments was from self-reports rather than a consideration of the relevant records held. A broader consideration of this information would have allowed for a more thorough assessment.

114. While Mr Row Row's risk was reduced during this time from high to low, in terms of the change in circumstances, risk and protective factors, Dr McPhedran noted that there was little difference in the presence or absence of factors, particularly between 22 and 23 August when his risk was reduced to 'low'.[42]

[41] Ex G1, pg. 13 onwards
[42] Ex G1, pg. 21

115. In relation to the assessment carried out by Ms Haddock on 24 August 2016, when Mr Row Row's risk was maintained as 'low', Dr McPhedran noted that,

> *'given his ongoing anxiety in relation to Mr Ford as well as the expression of new risks in the form of active suicidal ideation and sleep disturbance, it is not clear why, on 24 August 2016, Mr Row Row's risk level was not elevated. The available records do not provide information that can shed light on why those newly emerged factors were not considered sufficient to merit a change in risk level.'*[43]

116. Dr McPhedran questioned why it was that Mr Row Row's request to be moved to the Health Centre was not viewed as help-seeking behaviour and further that isolation was clearly having an impact on him.[44] In addition, Dr McPhedran questioned why fluctuations in suicidal ideation, which Mr Row Row had described as intermittent, were not considered as indicative of swift fluctuations in his presentation from one point in time to another, which required caution in assessing his risk.[45] However, she agreed that rapid fluctuations in mood are possible, leading to rapid changes in risk.

117. Dr McPhedran also raised the apparent lack of transparency and records maintained by those charged with assessing Mr Row Row's risk, particularly as to how risk and protective factors were balanced against one another.[46] It was also noted that there seemed to be an apparent misunderstanding of what 'future orientation' meant in the context of a risk assessment.[47]

118. In terms of the appropriateness of the treatment provided to Mr Row Row by CCC, Dr McPhedran noted the following:[48]

- While there was a therapeutic approach to risk management provided by the CLOs, there does not appear to have been steps taken to develop a formal, individualized, collaborative plan for Mr Row Row.

- It is preferable that re-assessment of an individual's risk over time be undertaken by the same clinician, to provide continuity of care and consistency in assessment, as well as build a therapeutic relationship between the clinician and the suicidal individual.

[43] Ex G1, pg. 24 & 25
[44] Ex G1, pg. 25
[45] Ex G1, pg. 29
[46] Ex G1, pg. 29
[47] Ex G1, pg. 30 & 31
[48] Ex G1, pg. 32 - 36

119. Dr McPhedran also highlighted an area of concern in Mr Row Row's case, which is a well-recognised issue in correctional settings, with respect to a lack of cultural specificity in the conceptualisation of psychological states, and as such a lack of culturally suitable risk assessment carried out on First Nations prisoners.[49] During her evidence, Dr McPhedran noted that a separate risk assessment form could be considered with respect to First Nations prisoners that recognised cultural sensitivities.

120. Responding to Dr McPhedran's report, Ms Haddock told the inquest that she had a Masters degree in Forensic Mental Health. She has also undergone several different types of training with respect to First Nations prisoners' suicide prevention, including training provided by First Nations psychologist, Dr Tracey Westermann.[50]

121. Ms Haddock further noted that to ensure culturally relevant considerations and needs were met, engagement with First Nations prisoners by the psychological staff included, whenever possible, the CLOs. Ms Haddock said that other prison staff including CLOs undergo the same basic risk assessment training and training in suicide prevention and awareness on an ongoing basis.[51]

122. Ms Haddock said that based on the IRNA and subsequent reporting Mr Row Row was not actively engaging in any self-harm behaviours. He was not receiving ongoing mental health support before the emergence of his suicidal expression in August 2016 because he did not meet the Elevated Baseline Risk threshold for such treatment within the QCS environment. He did not seek intervention from QCS, and he did not meet the criteria for a Prison Mental Health Service referral.[52]

123. Ms Haddock said that Mr Row Row was not returned to the health centre on 24 August 2016 because intermittent suicidal ideation fell within the "low risk" range according to the risk matrix. Additionally, the reasons Mr Row Row wanted to go back to the health centre were fully explored. Mr Row Row was accommodated in the Detention Unit because of the serious assault he had committed. But for that factor, he would have been returned to the less secure environment of his usual unit.

124. In response to Dr McPhedran's expert report Mr Peter Shaddock, Assistant Commissioner, Central and Northern Region Command, Custodial Operations provided the following additional comments:[53]

    - The practicalities of correctional environments are such that continuity of care is not possible nor is it encouraged for several reasons including; general HR issues associated with leave,

[49] Ex G1, pg. 38
[50] Including Suicide Risk Assessment for Aboriginal Clients and Aboriginal Mental Health and Suicide Prevention
[51] Including Suicide Prevention and Awareness and Protect the Safety of Aboriginal and Torres Strait Islander Offenders
[52] Ex B20.1
[53] Ex B42.8

rostering and the like; to prevent the burn out of staff, particularly with high care and high risk environments; reduction of the risk of corruption through rotation; promotion of professional development and to enhance performance.

- Continuity of care would prevent progression of individual prisoners throughout the correctional environment e.g., from Secure to Low custody and movement between centres. This would also impact negatively on pathway progressions which support parole applications and the movement of individual prisoners through the Correctional system in a staged, structured and supported manner.

- Operational aspects such as transfers for court or medical procedures mean that prisoners can be transferred and placed in another centre for many weeks or months.

- The RAT is now more involved in determining the placement of prisoners, which was not the case at the time of Mr Row Row's death. While the ultimate decision still rests with the operational staffing group, the RAT recommendation is a pivotal consideration.

- The participants in the RAT bring their own knowledge and experience to the assessment process. The CLO has cultural and the lived experience. The psychologist brings their professional expertise and practical daily hands on experience in recognising and balancing the risk and protective factors in a Correctional Centre environment. The supervisor has operational experience of how the prisoner usually presents in the unit and matters such as associations, work placement and employment, visits, activities, interventions/programs.

- A new At-Risk Management Practice Directive was implemented in 2018, which contained extensive practice and process improvements, including the adequacy of the documentation required.

Conclusions

125. The inquest considered the adequacy of the risk assessment process that took place in the days leading up to, and on the day of Mr Row Row's death. Mr Row Row's at risk level had been reduced from "high" to "low" in less than 48 hours. He was subsequently housed in the Detention Unit without constant or more regular observations. The Detention Unit was intended to be a "sterile environment" with no means for prisoners to self-harm.

126. ATSILS submitted that there was a deficiency in mental health and risk assessment training for staff tasked with assessing risk. It was also submitted that there was a lack of training in identifying mental health risk

factors and some confusion about how each participant's assessment was considered. ATSILS also highlighted that the RAT did not have the power to make placement decisions within the centre.[54]

127. I accept that the RAT members assessed Mr Row Row separately on 23 August 2016 and formed their own views about his level of risk based on their interactions with him and their reviews of IOMS. I accept the submission from QCS that there is value in having a multidisciplinary team which has the capacity to evaluate differing perspectives. I was not persuaded that the training provided to CSOs and CLOs in relation to risk assessment was inadequate.

128. I agree with the submission from QCS that the primary trigger for Mr Row Row's threats of self-harm was the assault on Mr Ford. Prior to that he had not displayed significant overt emotional distress during the months he had been at CCC.

129. Mr Row Row was extremely distressed after his assault on Mr Ford and the resulting injuries. Mr Row Row repeatedly asked the CLO, psychologist and correctional officers about Mr Ford's condition. While Mr Smith and Ms Speedy tried to alleviate his concerns, no one was able to provide him with specific information and did not obtain it in a timely way to lessen his distress.

130. While there were barriers to this (primarily confidentiality of sharing Mr Ford's medical status) the prison information systems were not updated until after Mr Row Row's death to indicate that Mr Ford was stable and did not want to pursue criminal charges against him.[55]

131. Mr Row Row told Ms Haddock on the morning of his death that he had thought of drowning himself in the toilet earlier that morning. However, he later confirmed he did not have suicidal ideation or plans.

132. As was noted by Dr McPhedran, it appears that there was a change of risk and protective factors on the morning of 24 August 2016. This may have warranted Mr Row Row's risk level being elevated. Notwithstanding, both Ms Haddock and Mr Smith shared the view that Mr Row Row was not at risk of self-harm or suicide following detailed discussions with him that morning. With the benefit of hindsight, his risk of suicide clearly escalated rapidly as that morning progressed and he was left alone in the Detention Unit.

133. With respect to the adequacy of the risk assessments conducted of Mr Row Row in the days leading up to his death, it appears (also with the benefit of hindsight) that there were missed opportunities to identify a change in risk and protective factors that may have warranted the elevation in his level of risk.

[54] As noted above, the RAT now has a specific role in placement decisions.
[55] Ex C74

134. Further consideration of Mr Row Row's history and an examination beyond his self-reporting with consideration of factors such as impulsivity may have resulted in a different assessed level of risk. However, as was acknowledged by Dr McPhedran assessing an individual's risk of suicide is exceptionally challenging in a correctional setting.

135. Mr Row Row fashioned a noose and took his own life within 17 minutes before he was found hanged. Even if Mr Row Row's level of risk had been elevated to 'Medium' or "High" with observations required every hour or 15 minutes, it is not clear that this would have significantly altered the outcome as he was left in the Detention Unit with the exercise yard door open.

136. ATSILS submitted there was a lack of continuity of care for Mr Row Row, who was assessed three times in three days by two different psychologists. ATSILS referred to s37 of the *Human Rights Act 2019* which provides that every person has the right to access health services without discrimination, as well recommendation 150 from the Royal Commission into Aboriginal Deaths in Custody that prisoners should have equivalent access to mental health services. Given his ready access to psychological and cultural support, I am unable to conclude that that Mr Row Row was discriminated against in relation to the mental health services that were available while in custody.[56]

137. ASTILS also submitted that the risk assessment protocols were not specific for First Nations prisoners and did not reflect the differences and unique challenges First Nations prisoners face. It was also submitted that male psychologists should be employed to ensure a more culturally appropriate service is provided to First Nations prisoners.

138. Ideally, as was noted by Dr McPhedran, it would be beneficial for a prisoner to have consistency in psychological care and assessment, including a psychologist of the same gender as a First Nations prisoner where appropriate. However, I accept that this is not always practical in a correctional setting for a variety of operational and logistical reasons as outlined by Mr Shaddock.

139. While Mr Row Row had the benefit of a consistent relationship with the CLOs who both knew his extended family in the local community, he was not receiving ongoing mental health support or treatment while in the custody of QCS. The focus of his interactions with prison psychologists was suicide risk assessment. He did not receive any ongoing mental health treatment or support from Queensland Health or another agency.

140. On the morning of his death, Mr Row Row was seen by Ms Haddock and Mr Smith within 20 minutes after Mr Marschke raised concerns about his presentation. Ms Haddock's evidence made it clear that she was familiar with the importance of cultural issues including shame, men's business and family connection. She had undertaken specific training on those matters.

[56] These were focussed on risk assessment.

141. Dr McPhedran also identified several shortcomings in terms of the documentation which was produced in relation to each of the risk assessments. Those shortcomings have been acknowledged and rectified by way of extensive amendment and improvement to the process mandated by the reviewed Practice Direction, which has been in place now since 2018.

142. I am also satisfied that significant steps have been taken by way of training and amendment to policy and procedure to address the shortcomings identified in the OCI investigation.

143. It is apparent that there was not sufficient detail in the Safety Order for CCO Marschke in relation to whether the exercise yard door could remain open while Mr Row Row was housed in the Detention Unit. It was common practice to leave the exercise yard door open in the Detention Unit for most of the day without continuous observations (in contravention of the COPD).

144. While I consider that QCS adequately provided for Mr Row Row's physical care at Capricornia Correctional Centre prior to his death, there was inadequate staffing in the Detention Unit to monitor his wellbeing on the day of his death.

145. In practical terms, Mr Row Row’s death could have been prevented if the internal door to the exercise yard was closed, removing the hanging point, coupled with continuous observation. It is unfortunate that a local process, contrary to the Risk Management Practice Direction in place, had been adopted at CCC, which allowed the door to simply be left open for prisoners such as Mr Row Row.

146. Following his death, the local process stopped, with training and signage immediately implemented to ensure a similar event did not take place. In addition, all local processes in place at CCC were reviewed to ensure that they were compliant with the applicable practice directions. Staff were notified of any such necessary changes by supervisors to ensure consistency. In addition, staffing within the Detention Unit has been changed to ensure two staff members are now always rostered within the unit.

Findings required by s. 45

147. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all the evidence, I make the following findings:

Identity of the deceased – Frederick Arthur James Row Row

How he died – Mr Row Row had a lengthy criminal history. While he had also experienced significant and cumulative trauma and grief, he did not meet the criteria for ongoing mental health support in prison. At the time of his death, he was affected by numerous stressors, including concerns about his relationships with family members and a further lengthy term of imprisonment after his assault on another prisoner on 21 August 2016. Mr Row Row was assessed as being at low risk of self-harm on 23 August 2016. That day was also his birthday. On the morning of his death, he was distressed and again expressed fleeting suicidal ideation. He was not placed on an increased observations regime. He died later that day after he intentionally hanged himself with a bed sheet in the doorway of his cell and exercise yard.

Place of death – Capricornia Correctional Centre, Bruce Highway, North Rockhampton QLD 4701

Date of death– 24 August 2016

Cause of death – Neck compression

Comments and recommendations

148. Section 46 of the *Coroners Act*, as far it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

149. The submissions from the family proposed:

- Targeted recruitment be undertaken to employ male psychologists to ensure there are more culturally appropriate services provided to First Nations prisoners;
- More and better training around risk assessment, especially for the issues unique to First Nations prisoners, for those staff involved in risk assessment teams;
- More and better cultural awareness training for staff;
- More funding to improve psychological and mental health services within correctional centres and allowing community-based providers access to the Correctional Centre to enhance service delivery.

150. The 2018 Offender Health Services Report[57] noted the findings from the 1991 Royal Commission into Aboriginal Deaths in Custody, which identified support for mental health and treatment for mental illness as priorities for First Nations people in custody and in the broader community.

151. Rates of overrepresentation of First Nations people in custody have increased significantly in the 30 years since the Royal Commission. Data from the Queensland Government Statistician's Office in 2020 indicates that over one-third (35.1%) of all adults in custody in Queensland identified as Aboriginal and/or Torres Strait Islander. The Aboriginal and Torres Strait Islander imprisonment rate (2,121.1 per 100,000 persons aged 18 years and over) was 14.5 times the imprisonment rate for others (146.0).[58]

152. The Offender Health Services Report also noted a 2012 Queensland study which found that the 12 month mental illness prevalence among Aboriginal prisoners in Queensland was 73 per cent among males and 86 per cent among females. This compared to 20 per cent among the general population and 41 per cent among non-Aboriginal prisoners. The most prevalent forms of mental illness were substance use and affective disorders, which were 13 times greater among males and 14 times among females when compared to the general population.[59]

153. The 2018 Offender Health Services Report found that for mental health services for First Nations people to be effective, "*they must be culturally*

[57] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/improvement/Offender-Health-Services-Review-Report.pdf

[58] https://www.qgso.qld.gov.au/issues/7876/justice-report-qld-2019-20.pdf

[59] Heffernan et. al (2012). *Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons*. MJA 197 (1)

capable, and accessible both in custody and in the community, with a focus on enabling continuity of care between the two".

154. The Office for Prisoner Health and Wellbeing was established in Queensland Health in response to the Offender Health Services Report. September 2020 saw the publication of *Reducing barriers to health and wellbeing: The Queensland Prisoner Health and Wellbeing Strategy 2020–2025*. Included within the actions outlines in the strategy is the following:

    Improve the quality of health services and capacity to deliver culturally competent, trauma informed, gender specific services in response to the health needs of all prisoners, including Aboriginal and Torres Strait Islander peoples, women, older people and people with disability.

155. I am conscious that it is over five years since Mr Row Row's death. However, consultation with Queensland prisoners by the Office for Prisoner Health and Wellbeing in early 2021 identified that access to mental health treatment options remains a significant concern for prisoners.[60]

156. I am not confident that the unmet need for culturally appropriate mental health responses for First Nations prisoners identified in this inquest has been addressed in a significant way. However, there are several recent initiatives that may assist in this regard, including:

    - Queensland's 2021 Closing the Gap Implementation Plan;[61]
    - Making Tracks Together – Queensland's Aboriginal and Torres Strait Islander Health Equity Framework;[62] and
    - Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-23.[63]

157. The Closing the Gap Implementation Plan includes targets related to reductions in overrepresentation in the criminal justice system and suicide. Each of the plans recognise that successful implementation requires leadership and shared decision-making with First Nations peoples and the need for communities to be engaged in the co-design of initiatives to strengthen mental health and social and emotional wellbeing, respond to problematic substance use and reduce suicide.

158. The *Hospital and Health Boards Act 2011* and *Hospital and Health Boards Regulation 2012*, were also amended in April 2021 to require all HHS to develop and publish a Health Equity Strategy by 30 April 2022. These strategies are to be co-designed, co-owned and co-implemented with stakeholders including First Nations staff and consumers "to ensure place-based and culturally capable solutions to local health priorities". The

[60] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/about-us/what-we-do/office-prisoner-health-and-wellbeing/prisoner-health-consumer-perspective.pdf
[61] Closing Gap Implementation Plan (dsdsatsip.qld.gov.au). This Plan includes targets related to reductions in overrepresentation in the criminal justice system and suicide.
[62] health-equity-framework.pdf
[63] Strategic plan | Queensland Mental Health Commission (qmhc.qld.gov.au)

Health Equity Strategy requires each HHS to publish performance measures on matters such as “actively eliminating racial discrimination and institutional racism” and “delivering sustainable, culturally safe and responsive healthcare services”.

159. This inquest was focussed on the response of Queensland Corrective Services to Mr Row Row’s immediate needs rather than the broader mental health needs of First Nations people in custody and the response of agencies such as Queensland Health. Having regard to the range of existing plans in place, I will refer my findings to the Closing the Gap Partnership Committee for consideration in the implementation of the strategies referred to above.

160. After considering the response from QCS to the recommendations in the OCI report and the issues that the family’s submissions seek to address I am satisfied that no further recommendations should be made.

161. I close the inquest.

Terry Ryan
State Coroner
BRISBANE