QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Anthony Mark PERRY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/992
DELIVERED ON:	31 May 2012
DELIVERED AT:	Rockhampton
HEARING DATE(s):	9 March 2012, 29-30 May 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody - police watch house; accidental overdose; assessment of intoxicated prisoners

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Family of Mr Perry:	Mr Liam Dollar (instructed by Callaghan Lawyers)
Queensland Police Commissioner:	Ms Belinda Wadley
Sergeant Turner, Constable Danello, Sergeant Noake, Mr Collins & Mr Moffit:	Mr Adrian Braithwaite (Gilshenan & Luton Legal Group)

Table of contents

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 Anthony Mark Perry. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

In the early hours of 23 March 2010, Anthony Perry, 41, died in the Rockhampton watch house, some five hours after he had been taken into custody.

At the time of his arrest officers were told Mr Perry had been drinking heavily throughout the day. They were not told he had ingested morphine.

The watch house sergeant considered no expert medical review of Mr Perry's fitness to be kept in the watch house was necessary as his symptoms were consistent with severe intoxication only. He was subject to a "pat down" search but his clothes were not removed and searched nor was his person.

As late as 11:40pm on 22 March 2010, three hours after his arrival at the watch house, Mr Perry was capable of walking unaided, conversing at a reasonable level and making his bed. However, when checked shortly after 2:00am the following morning he was found not to be breathing and could not be revived.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the police charged with providing for the deceased's health care needs while he was in custody adequately discharged those responsibilities;
- determine whether police otherwise adhered to the requirements set out in Queensland Police Service (QPS) operational procedures manual (OPM); and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Inspector Gerry Walton of the QPS Ethical Standards Command (ESC), Internal Investigations Branch headed the investigation into the death of Mr Perry and later provided me with a detailed report of that investigation.
In the immediate aftermath of Mr Perry's death the scene was secured by the Regional Duty Officer, Inspector Knapp. The District Officer, Acting Superintendent Crier later attended the scene. The ESC was advised of Mr Perry's death at 3:00am and officers arrived at Rockhampton watch house at 3:40am.

QPS scenes of crime officers conducted an examination of the cells in which Mr Perry had been accommodated under the supervision of ESC investigators. Samples from four small spots of blood found in cell H4 and a sample of a foreign substance found in the toilet of the same cell were sent for forensic testing. Photographs were taken of each of the cells in which Mr Perry had been accommodated and of his body as it lay *in situ*. The ESC investigators conducted interviews with all watch house officers who had been in contact with Mr Perry. Interviews were later conducted with family, friends and associates of Mr Perry.

Video footage from within the Rockhampton watch house was seized by ESC investigators as were logbooks, medical records and other paperwork relating to either Mr Perry specifically or to the operations of the watch house on the relevant evening more generally.

The residence in which Mr Perry and his partner had been living and the house of Mr Perry's mother were both declared crime scenes and searched. Aspects of this were done in a somewhat heavy handed manner, something I shall refer to later.

I am of the view the investigation was comprehensive and independent. I commend Inspector Dalton and those who assisted him on their endeavours.

The Inquest

A pre-inquest conference was held in Brisbane on 9 March 2012. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to Mr Perry's family, the Queensland Police Commissioner and several individual officers involved in managing the custody of Mr Perry at Rockhampton watch house.

An inquest was held in Rockhampton on 29 and 30 May 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Seven witnesses gave oral evidence and 115 exhibits were tendered.

The evidence

Personal circumstances

Anthony Mark Perry was born on 6 June 1968 at Rockhampton. Throughout his life he endured many hardships. He was in an orphanage for a number of years when he was very young; he commenced abusing illicit drugs when he was 12 or 13; he left school at 13; he spent many of his teenage years living on the street; he was imprisoned on a number of occasions for offences of dishonesty and drug matters.

At the time of his death he was residing with his partner, Tracy Davies, at Parkhurst on the outskirts of Rockhampton. They had a volatile relationship that had resulted in Mr Perry being made the subject of a Domestic Violence Order on 14 July 2009.

Mr Perry's medical history is a complex one and includes diagnoses of antisocial personality, drug induced psychosis, asthma and as a carrier of haemochromatosis. At the time of his death he was prescribed and was taking a number of antipsychotic and sedating medications including Seroquel and Valium. He had not been prescribed morphine.

Events leading to arrest

At 4:45pm on Monday, 22 March 2010 Tracy Davies called North Rockhampton police to seek assistance in moving out of the residence where she and her partner, Anthony Perry, were living. The two uniformed officers who attended on Ms Davies were told she and Mr Perry had been drinking "*tallies*" of VB beer that day and over the previous two days she and Mr Perry had been smoking marijuana. She told police that earlier in the day the two of them had become involved in an argument during which Mr Perry struck her with his hat and threw a folding chair at her. She said he threatened to cut her throat while he was holding a pocket knife.

Ms Davies was seeking the assistance of police to ensure her safety while she returned to the residence and collected her property. It was her intention to move out. One of the two police officers who attended on Ms Davies, Constable Cara Danello, gave evidence at the inquest. She told the court that soon after receiving the complaint, she discovered there was a domestic violence order already in place in which Ms Davies was named as the aggrieved and Mr Perry, the respondent. It contained the usual conditions requiring Mr Perry to refrain from committing domestic violence towards Ms Davies.

The police assisted Ms Davies to obtain her property and, having taken her complaint, took steps to locate Mr Perry.

Earlier in the afternoon, after the fight with Ms Davies, Mr Perry had telephoned his mother, Robyn Bloxson. He told her of the fight with Ms Davies and asked to be picked up. Ms Bloxson arrived at Mr Perry's residence to find him asleep on the front steps. He drank another *tallie* and she then drove him

back to her house. At around 5:00pm Ms Bloxsom heard Mr Perry make a telephone call to a friend named “Peter”. After getting off the phone Mr Perry asked her to drive him and “Peter” to Yeppoon. He told her the purpose of this trip was to collect some money owed to him by a person in that town.

Ms Bloxson drove Mr Perry and the person we now know as his associate, Peter Foreman, to an address in Yeppoon where he told her a man called Teapot lived. Once at the address Ms Bloxson had to wake Mr Perry. He went into a house and returned to the car after about five minutes He showed Mr Foreman a grey tablet which he said was morphine and which he said he had bought from Teapot for $40.

It is now known that Teapot’s real name is Paul Templeton. He told investigators he supplied Mr Perry with a Kapanol tablet - a morphine-based painkiller which had been prescribed to Mr Templeton. He told police Mr Perry appeared agitated and told him he was “*crook*” which Mr Templeton took to be a reference to his suffering withdrawal symptoms from earlier drug use. Mr Templeton has subsequently been convicted of a criminal offence as a result of his actions that day.

After getting back into the car Mr Perry asked his mother for five dollars which he used to buy a bottle of water from a service station. Mr Perry then had his mother drive him to the Yeppoon Hospital. Ms Bloxson told police she wasn't sure what Mr Perry was doing at the hospital but on his return to the car he requested she take him to get another bottle of water which she did.

Mr Foreman said they went to the Yeppoon Hospital to buy syringes after earlier failing to obtain any at a chemist. After obtaining syringes from the hospital they went to the car park of a fast food outlet and Mr Perry prepared and then twice injected the morphine. Mr Foreman then injected himself with about “*half of a syringe*”.

Mr Perry fell asleep shortly after they set off on the return journey to Rockhampton.

Mr Foreman was dropped back to his house at around 7:00pm and that is the last time he saw Mr Perry. Ms Bloxson and Mr Perry returned to her house. Mr Perry made toasted sandwiches and poured a glass of milk. Ms Bloxson told police at this time he was acting in an unusual manner. He began talking indirectly of suicide while briefly holding a pocket knife near his throat, but was otherwise so listless Ms Bloxson says he could barely lift his glass.

At 8:34pm Constable Danello and her partner arrived at the house. They knocked a number of times and after a minute or so Mr Perry opened the door. This encounter was audio tape recorded. Mr Perry can be heard slurring his words which were on occasions incomprehensible. Constable Danello said he was unsteady and appeared very drowsy, seeming to almost fall asleep on his feet at one stage. In her statement she recorded “*his eyes rolled back a few times*” and “*He kept closing his eyes as if he was falling asleep*”. After questioning him in relation to the allegations made by Ms Davies, Constable

Danello arrested Mr Perry for a suspected breach of a domestic violence order. She followed him when he went back into the house and finished some food before leaving with the officers. As they were leaving the house Ms Bloxsom told the police officers "*watch out for him, he's been drinking*".

Constable Danello said Mr Perry did not require assistance to descend the stairs at the front of the house and made his way to the police car without assistance.

Before he was transported to the watch house Mr Perry was subjected to a pat-down search by the other officer present Sergeant Joseph Aboud. In the course of this search the officer located a brass cone used for smoking marijuana and a pocket knife.

Rockhampton watch house

After arriving at the watch house, Mr Perry was temporarily placed in cell H2. CCTV recorded vision shows him being taken from the vehicle bay and placed in this holding cell. The video corroborates the contention of various police officers that although unsteady on his feet Mr Perry was able to walk unaided.

The watch house keeper on duty was Sergeant Mark Turner. He processed Mr Perry in relation to a charge of breaching a domestic violence order. It was decided by Constable Danello, the arresting officer, that she would delay any charges relating to the possession of the knife and the cone until Mr Perry was sober enough to be questioned in relation to those matters.

In the course of Mr Perry being received at the watch house he was searched again, this time by watch house assistant Mark Collins. That search, as with the previous one, consisted only of a pat-down over the outside of his clothes. It did not involve the removal of any clothing. Nothing of note was found.

Sergeant Turner then asked Mr Perry a number of questions set out in pro forma QPS documentation used during the receipt of all watch house prisoners. Sergeant Turner recorded the answers which include the officer's assessment that Mr Perry was "*very intoxicated-hard to interpret conversations/answers"* He also noted he was "*very slurring, very unsteady on his feet, falling asleep at the counter*". However, Sergeant Turner and Mr Collins both said Mr Perry was able to walk unaided, he understood what was being said to him and he complied with their directions.

In answer to a question; "*Are you affected or intoxicated by alcohol, prescription or non prescription drugs?* He answered; "*Yes*". In answer to the next question; "*What did you take/drink?*" He answered; *"VB*"

Once the questioning was completed Sergeant Turner directed Mr Collins to take Mr Perry to cell H4. Mr Perry was able to walk unassisted to the cell. Sergeant Turner then told Mr Collins to "*keep an eye*" on Mr Perry and to "*Put him up on a monitor"*, a reference to the capacity of the cctv system to be adjusted so that a particular cell was under constant surveillance. He recalls

seeing Mr Perry standing up for a period of time after he had been placed in the cell. A short time later while escorting another prisoner, Mr Collins recalls looking into Mr Perry's cell and seeing him sitting upright on the bed.

Although Mr Collins could see into the cell via the monitor, it was later discovered the recording facility for this particular cell was not working at the relevant time. Therefore no recorded vision of Mr Perry's movements within cell H4 was available to investigators or to be tendered at the inquest. This deficiency is dealt with later in these findings.

Sergeant Turner was questioned at the inquest about his decision to hold the "*very intoxicated*" Mr Perry in the watch house without having him first reviewed by a medic or paramedic. He told the inquest that although Mr Perry was markedly affected by alcohol, the fact he could walk unaided and respond to questioning satisfied the sergeant no medical assessment was required. He said he made sure watch house assistant Collins paid particular attention to Mr Perry and said he would have organised a medical examination had Mr Perry's condition deteriorated. However, Sergeant Turner considered Mr Perry's indicia of intoxication were consistent with his having been drinking throughout the day and did not lead him to suspect there was anything else such as drugs or disease contributing to his behaviour.

At 10:00pm there was a change of shift at the watch house with Acting Sergeant Amanda Noake taking over from Sergeant Turner and watch house officer Jeffrey Moffitt taking over from watch house officer Collins. During the change of shift when the outgoing officer reviewed all of the prisoners for the benefit of his replacement, Sergeant Turner emphasised Mr Perry was very intoxicated and suggested he be monitored closely.

Visual checks of Mr Perry were conducted at 10:21pm and 10:56pm. Nothing out of the ordinary was noticed At 11:37pm Acting Sergeant Noake and watch house assistant Moffitt moved Mr Perry from cell H4 to cell B1 for the night. This movement was recorded on the cctv system. Mr Perry can be observed walking unassisted. The two watch house officers say he was conversing with them during this brief period. After he entered the cell B1, he put on his t-shirt and arranged his bedding, before sitting on the bed for some time. He then lay down and appeared to go to sleep.

Watch house assistant Moffitt conducted visual checks of Mr Perry at 12:20am and 1:21am. He told the inquest on both of these occasions he could hear Mr Perry snoring and observed his chest rising and falling.

Discovery of the death

At 2:05am Acting Sergeant Noake conducted a routine visual inspection of the prisoners. She discovered Mr Perry was not breathing and after alerting watch house officer Moffitt and the communications centre she opened the door to cell B1. They attempted to revive Mr Perry. These were continued by a crew of general duties officers who came to the watch house to assist. Those officers continued resuscitation attempts until the arrival of Queensland Ambulance Service (QAS) paramedics. The QAS had been called at 2:09am

and paramedics were in attendance three minutes later at 2:12am. An intensive-care paramedic arrived at 2:22am. The paramedic reported that when the arrived Mr Perry had no pulse or respiration, his pupils were fixed and dilated. Resuscitation attempts continued unsuccessfully until 2:36am at which time a life extinct form was issued by QAS officer Baxter. It is likely Mr Perry was already dead when he was found.

A short time later each of the cells that had been occupied by Mr Perry were sealed off and investigations into his death commenced.

The body of Mr Perry was transported to the Rockhampton Hospital morgue. Mr Perry's brother-in-law, Terence Williams, identified his body.

Autopsy results

An external and full internal autopsy examination was conducted on the body of Mr Perry on 23 March 2010 by an experienced forensic pathologist Dr Nigel Buxton. After considering toxicology and histology results Dr Buxton issued a report in which he stated (*emphasis is Dr Buxton's*):-

> *"There is no evidence that a second person played a physical role in this man's death. There is no evidence of bruising or other trauma to suggest the patient has been involved in a fight. There is no evidence of shackling over the wrists or ankles. There is no evidence of significant pre-existing natural illness.*
>
> *Death in this man is a result of respiratory depression as a result of a high morphine level in association with alcohol. Small amounts of benzodiazepines were present along with Quetiapine (an anti-psychotic drug) by these drugs are only seen in sub therapeutic amounts. The observed "snoring" is consistent with the mode of death.*
>
> *The levels of morphine present at autopsy would NOT reflect the peak level attained - nor the level present when the deceased was placed in the watch house. With ongoing metabolism, the drug levels would have been higher earlier in the night UNLESS he had access to drugs whilst IN the watch house. There is no indication that illicit drugs were available. A higher level of morphine would have led to respiratory embarrassment and resulted in death, the alcohol would have contributed to the respiratory depression. There is no way of telling at autopsy if the high level of morphine was deliberate or accidental."*

As a result of his findings, Dr Buxton issued a certificate listing the cause of death as:

> *1(a) Respiratory depression,* due to, or as a consequence of
> *1(b) Poisoning by morphine and alcohol*

Investigation findings

Samples taken from the four blood spots located in cell H4 were tested at the DNA analysis unit of Queensland Health Forensic and Scientific Services

(QHFSS). Three of the blood spots were found to have DNA that matched that of Mr Perry, while the fourth did not.

The sample of the foreign substance found in the toilet of cell H4 was found by QHFSS to be either phlegm or a related biological substance expelled by spitting. No opiates (including morphine) were found within this sample.

While the cause of this blood loss can't be established, there is no evidence they were the result of any improper violence done to Mr Perry. The small spots in H4 are likely to have been coughed up by Mr Perry and the larger amount in B1 may either have been regurgitated during resuscitation attempts or produced by the multiple unsuccessful attempts of the QAS paramedics to gain venous access via Mr Perry's arms and neck.

A search of Mr Perry's mothers address and at the address of Tracy Davies revealed no illegal substances.

Report of Dr Ian Mahoney

After receiving the brief of evidence from the ESC, counsel assisting sought the opinion of Dr Ian Mahoney a forensic medical officer attached to the Queensland Health, Clinical Forensic Medicine Unit.

Dr Mahoney was asked to consider the likely treatment (if any) a medical officer would have provided, if called to assess Mr Perry after he arrived at the Rockhampton watch house. He was also asked to consider whether such treatment would have been likely to result in a different outcome for Mr Perry. Dr Mahoney gave evidence at the inquest, maintaining the opinion proffered in his report, namely, that in the absence of any specific history of morphine use, the known history of alcohol use and suspected marijuana use would have been sufficient to explain Mr Perry signs of intoxication. Given his presentation, no medical treatment would have been recommended.

Dr Mahoney agreed that respiratory depression caused by morphine is in theory a preventable death as the effects of the morphine could be rendered non lethal through the administration of "*the specific opoid antagonist naloxone*" and the use of oxygen. He considered this irrelevant to the circumstances concerning Mr Perry as such treatment would only be administered if it was known he had taken morphine.

Dr Mahoney usefully explored the likely mechanics and effects of morphine use in the context of the facts discovered after Mr Perry's death. Dr Mahoney noted Kapanol and MS Contin, both orally ingestible sources of morphine, are designed to be used once or twice a day by patients with chronic pain. They contain a preparation designed for slow release into the body with peak levels occurring two to three hours after the dose. The morphine levels thereafter have a half-life averaging eight hours. He explained the level of morphine in the system by itself is of limited assistance to an investigator as the effect on a patient will greatly vary depending on tolerance.

In this case, the evidence of Mr Foreman is that the Kapanol tablet was crushed up and injected. Dr Mahoney says the description of the tablet as “grey” was in fact more consistent with MS Contin. If the drug was injected, Dr Mahoney told the inquest that maximum blood concentration would be reached within a few minutes and afterwards the levels in the blood should be falling. This would be consistent with the observation of Mr Perry falling asleep on the trip back from Yeppoon to Rockhampton shortly after injection.

Yet Mr Perry died from respiratory depression some nine hours after Mr Foreman says this morphine was intravenously injected. Dr Mahoney told the inquest that the death in the early hours of 23 March 2010, more than five hours after he was placed in custody, would have required ingestion of morphine either around the time of his arrest or sometime later. Dr Mahoney agreed ingestion of a slow-release morphine tablet or tablets around the time he was arrested would result in a peak morphine concentration earlier than when Mr Perry died but still sufficiently close that it could explain the timing of his death. Alternatively, the time of death could indicate he had ingested morphine in the watch house.

Conclusions

The medical evidence concerning the rate at which morphine is metabolised makes it most unlikely that the drug which Mr Perry injected in the afternoon at Yeppoon would produce the blood levels found at autopsy or result in his death.

Although Mr Templeton said he sold only one morphine tablet to Mr Perry, the more likely scenario is that Mr Perry would not have been satisfied with a single dose. I expect he bought, or was given, several tablets.

It is possible Mr Perry ingested one of these slow-release tablets shortly prior to his arrest. It is also possible Mr Perry was able to smuggle one or more of them into the watch house. In the absence of a full strip search this could easily be done. That is not a criticism of the watch house officers - a strip search was not warranted or justified. Although existing cctv vision does not show Mr Perry ingesting any item, he could well have done so while being held in a cell H4 – the period for which no recorded cctv vision is available.

I conclude the arrest of Mr Perry was conducted appropriately and professionally as was his initial search and transport to the Rockhampton watch house.

I accept watch house staff acted reasonably when they assumed his intoxication was due to the ingestion of alcohol alone. In those circumstances their decision not to have him reviewed by a doctor or paramedic was also reasonable.

In any event, I also accept had a medical practitioner been called to the watch house when Mr Perry was being admitted it is likely he or she would have advised the watch house keeper that Mr Perry was fit to be held in custody

and no treatment would have been provided to Mr Perry of a nature that would have resulted in a different outcome.

I am satisfied he was monitored adequately and once discovered not to be breathing, medical attention was prompt. Everything that could be done to save him was done but, sadly, it is now clear he was by then beyond resuscitation.

Findings required by s45

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. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased person was Anthony Mark Perry

How he died - While in custody in a police watch house, Mr Perry died accidentally as a result of respiratory depression caused by self administered alcohol and drugs.

Place of death – He died at Rockhampton in Queensland

Date of death – He died on 23 March 2010

Cause of death – Mr Perry died from respiratory depression caused by alcohol and morphine poisoning.

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.

In this case, the following issues prompt consideration of comment from that perspective:

- Medical review of prisoners;
- CCTV equipment at Rockhampton watch house;
- Notification of family of the deceased; and
- Advice re coronial processes.

Medical review of prisoners

Section 16.13 of the QPS Operational Procedures Manual (OPM) is concerned with the health of persons in custody. It includes the following order:

> "*Every prisoner, whether held in a watch house or not, is to be assessed and reassessed as appropriate using Appendix 16.1.*

Where the responsible officer is unsure whether medical assistance or a medical assessment is required for that prisoner, medical advice, assessment or treatment is to be obtained."

It sets out QPS policy as follows:

"*The responsible officer must immediately assess and re-assess as appropriate the level of supervision and health requirements for a prisoner where the prisoner:*
(i)….
...
(viii) is believed to be heavily intoxicated by drugs;…"

Appendix 16.1 of the OPM, referred to above, consists of four checklists designed to assist officers in their assessment of prisoners; in particular in order to determine whether the prisoner should be assessed by a doctor or paramedic.

The first of those lists requires the officer to assess the "*best verbal response*" a prisoner is able to give. Applying that checklist to the circumstances of Mr Perry's case I accept he would have been classified as "*oriented*", in that he satisfied the requirement of knowing and clearly stating his name and where he was. The next level, "*confused*" applies in circumstances where a person is unable to state their name, date or where they are. Mr Perry was not so intoxicated. On the application of this checklist, no action further was required other than to proceed to consider the second checklist - the Health Questionnaire.

This involves the watch house keeper asking a list of health care related questions and recording the answers. As described earlier they were appropriately administered in this case.

The third and fourth checklists set out a number of "*conditions, symptoms, behaviours or signs*". At the time of Mr Perry's death, the presence of any of those was stipulated to *"generally require*" medical attention with two different levels of urgency. The third and fourth checklists both refer to "drowsiness" in a way that would encompass the appearance of Mr Perry on the evening of 22 March 2010. The checklists in force at the relevant time were not prescriptive - the watch house officer retained a degree of discretion but was given little guidance as to what he should consider when exercising it.

These checklists have since been amended with the removal of the term *"generally*". They now mandate an attempt to obtain medical attention if such "*conditions, symptoms, behaviours or signs*" are present or provide for specific monitoring until such medical attention is available.

Another section of the OPM, appendix 16.12, is also relevant to this matter. It deals specifically with drug and alcohol intoxication, overdose and withdrawal. Relevantly, it emphasises that many serious conditions may be consistent with or generate symptoms generally associated with intoxication. One of

these conditions is a mixture of alcohol and drug overdose. It gives no guidance as to how the causes of intoxication may be distinguished and seems to focus on stimulants rather than sedatives, which may be harder to detect.

At the inquest Sergeant Turner candidly stated he had not taken any steps to investigate whether Mr Perry's intoxication was caused by anything other than alcohol. He also stated he had not considered seeking medical attention for Mr Perry. It could be argued his approach is contrary to that encapsulated in the OPM's. Nonetheless, the decision not to seek medical attention was a reasonable one when considered against an application of the policy. Mr Perry was not so drowsy as to make the exercise of the discretion not to call for a medical assessment unreasonable. I expect had Mr Perry shown signs of deterioration after he was accepted into the watch house, medical attention would have been sought.

As mentioned earlier, the question in the Health Questionnaire relating to drug and alcohol consumption is a composite one that relates to alcohol, illicit drugs and prescription drugs. Sergeant Turner acknowledged prisoners will frequently admit to drug use if asked, but no guidance is given to officers as to how they might distinguish between alcohol and mixed alcohol and drug intoxication.

Recommendation 1- Mixed alcohol and drug intoxication

A high proportion of watch house prisoners are affected by alcohol, prescription drugs, illicit drugs or a combination of those substances. Determining whether a prisoner who appears intoxicated may also be affected by a drug other than alcohol is difficult but important because combining drugs may make them more dangerous. To assist officers in this regard I recommend the Health Questionnaire be reviewed with a view to including separate questions about the ingestion of each of those substances and the inclusion in Appendix 16.12 of the OPMs of a list of clues or signs that indicate drugs other than alcohol might be responsible for the symptoms a prisoner is displaying.

CCTV equipment at Rockhampton watch house

As detailed earlier, the cctv in one of the cells occupied by Mr Perry was not recording and had previously failed. I am satisfied the immediate problem in cell H4 has now been addressed. However, it is apparent from the statement of a senior officer attached to the watch house that the equipment is old, likely to suffer more failures in future and has limited technical capabilities.

Recommendation 2 – Replacement of cctv

In view of the important role cctv plays in monitoring prisoners and investigating incidents that inevitably occur in watch houses, more up to date and reliable equipment than that presently in use in the Rockhampton Watch house is highly desirable. Accordingly, I recommend the QPS give priority to its replacement.

Notification of family of the deceased

There was a need to search Ms Bloxsom's residence to ascertain whether drugs that may have been involved in her son's death were present. However that could have been achieved without adding to her distress and it should not have been given a higher priority than advising her of the death in a sensitive manner

Ms Bloxson said she was required by two officers who attended her house in the early hours of the morning to immediately leave her house and wait outside in her nightwear. She said initially, she was not even informed of Mr Perry's death. Only on pressing for an answer as to her son's whereabouts was she told he had died and, then, given factually incorrect information as to where he had died. She said no support was offered or counselling service recommended although she acknowledged through her counsel that some officers had been appropriately considerate and respectful of her position in later dealings.

QPS policies, via a Commissioner's directive set out the following requirements for police officers dealing with the notification of families who have had a loved one die in custody:

> *PROCEDURE*
>
> *Investigating officers as part of their investigation should:*
>
> *(i) …*
>
> *(vi) immediately arrange for the next of kin or person previously nominated by the deceased to be notified. Cultural interests of the person being notified should be respected by using the cross cultural liaison officer, if practicable. Where the deceased is an Aboriginal person or Torres Strait Islander and there is a delay or inability to notify the next of kin, efforts to notify the next of kin should be recorded"*

The QPS OPM provides the following guide for notifying families of the death of a loved one (regardless of whether it was a death in custody):

> ***8.4.7 Advising relatives***
>
> *POLICY*
>
> *Where a death has occurred, regardless of whether the death comes within the circumstances outlined in Part 3: 'Coroner's investigation, including by inquest, of deaths' of the Coroners Act, the Service will provide reasonable assistance to advise a deceased's family member of the death. This assistance will extend to, but is not limited to:*
>
> *(i) advising the nearest family member of the deceased;*

(ii) complying with any reasonable request of the nearest family member to locate and advise other relatives. Where practicable, assistance for this purpose should be offered; and

Officers who advise a relative or friend about a death of a deceased person should provide the person with a copy of the QP416: 'Coronial Investigations and the Police Response' handout where appropriate. Supplies of this handout are available from QPS Forms Select.

Recommendation 3 – Advising family members

It seems the QPS policies relating to how the relatives of a person who dies in custody are advised of the death may not have been complied with in this case. Because those concerns were raised for the first time at the inquest, the responses or explanations of the officers involved could not be sought. Accordingly, I recommend an appropriate officer within the Central Region ensure all officers stationed in Rockhampton are reminded of the importance of these policies

Coronial processes

Ms Bloxsom's counsel also advised the court his client received little information about the coronial investigation and processes. This is surprising in view of her early retention of experienced legal representatives. However, I readily acknowledge my office has a responsibility to ensure the next of kin are kept fully informed about such matters from an early stage. I note counsellors were, at my request, involved in resolving some disputes among family members but it may well be that Mr Perry's mother was not fully informed of the counselling services available to her. I will review the way the matter was handled initially to ensure any shortcomings do not recur.

I close the Inquest.

Michael Barnes
State Coroner
Rockhampton
31 May 2012