OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a prisoner**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 5138/08(6)
DELIVERED ON:	14 October 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 July 2011; 10 & 11 October 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, suicide

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Mrs Lynette Milligan:	Mr Brett Charrington (Russo Mahon Lawyers)
Department of Community Safety:	Mr Michael Nicholson
GEO Australia Pty Ltd:	Mr Sandy Horneman-Wren (Blake Dawson)
Prison Mental Health Service:	Mr Kevin Parrott (Crown Law)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of a prisoner.[1] They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

In the early hours of 3 September 2008 the deceased was found dead in his cell at the Arthur Gorrie Correctional Centre (AGCC) with a plastic bag secured over his head. He was 34 years of age and had spent almost six months in pre-trial custody at the time. The deceased had a sporadic psychiatric history and a history of attempting suicide.

These findings

- confirm the identity of the deceased person, how he died and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the deceased's health care needs adequately discharged those responsibilities; 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

The deceased's death was reported to the Corrective Services Investigation Unit (CSIU) and the investigation carried out by Detective Acting Sergeant Vesna Ciric.

Acting Sergeant Ciric attended AGCC with other CSIU officers at about 6:30am and made arrangements for the attendance of QPS forensics and photographic officers. Sergeant Ciric told the inquest she was satisfied with the arrangements put in place by QCS staff prior to her arrival. The lower landing of Unit A1, in which the deceased was housed, had been cordoned off and cell doors remained locked. I am content that the integrity of evidence at the scene was maintained.

The QPS forensic officers conducted a thorough examination of the deceased's cell. Letters apparently written by him were taken from the cell for further analysis.

[1] The deceased man has not been named as to do so would likely identify his wife in breach of s.82 of the *Domestic and Family Violence Protection Act* 1989

All records relating to the deceased were seized from AGCC together with rosters, transfer forms and plans relating to the unit where he was accommodated. Medical records from the Prison Mental Health Service (PMHS) were obtained and provided to the Office of the State Coroner.

Statements were obtained from corrective service officers (CSO's), prison mental health service (PMHS) staff and staff from AGCC involved in the risk assessment process. Other prisoners in Unit A1 were spoken to by CSIU officers.

Acting Sergeant Ciric accessed recordings of telephone calls made by the deceased in the weeks prior to his death.

On 3 September 2008 the deceased's body was transported to Queensland Forensic and Scientific Services where an external post mortem examination was conducted the following day. A blood sample was taken and underwent toxicological testing.

The Office of the Chief Inspector, Queensland Corrective Services commissioned a separate investigation and report into the circumstances surrounding the death of the deceased. That report was tendered at the inquest. It contained five recommendations which I will address later in these findings.

In addition to the material compiled by the CSIU and investigators appointed by QCC, Counsel Assisting sought a statement from Dr Aboud, the Director of the PMHS addressing that organisation's response to issues arising from the death of the deceased. GEO Australia Pty Ltd, the operators of AGCC, also provided further material to the inquest pursuant to an order requested by Counsel Assisting. A psychiatric report commissioned by the deceased's then criminal defence solicitors was tendered after it surfaced in the course of civil litigation linked to the death of the deceased.

I am satisfied all relevant material has been produced to the court and find the investigation into this matter was thoroughly and professionally conducted. I thank Acting Sergeant Ciric for her efforts.

The Inquest

An inquest was held in Brisbane on 10 and 11 October 2011. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the family of the deceased, the Department of Community Safety, GEO Australia Pty Ltd (the operators of AGCC) and the Prison Mental Health Service (part of Queensland Health).

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in

these reasons, the evidence I believe is necessary to understand the findings I have made.

Social history

The deceased was born on 29 August 1974 in Townsville, the younger of two boys born to his father Phillip and mother Lynette. His father committed suicide when he was 2 years old and he was brought up by his mother and later her second husband; residing in Townsville save for a brief stint at boarding school. He commenced but did not complete his senior schooling.

The deceased started working at age seventeen and remained employed for most of his adult life. He did this despite periods of heavy drinking, use of cannabis and occasional use of amphetamines. The deceased moved to Stanthorpe from Townsville early in 2007 to look for work. He was initially successful but had been out of work since late 2007 owing to the seasonal nature of his work. As at March 2008 the deceased had been married to his second wife for approximately one year. They had an infant girl and his wife was pregnant with their second child.

Custody

It is clear there had been ongoing tension between the deceased and his wife in relation to his drinking. The deceased appears to have abstained from alcohol for a period in early 2008 but by 8 March he had resumed drinking in apparent breach of a promise he had made to his wife. This led to his wife announcing she was leaving him and on 10 March she was in the process of speaking to real estate agents in preparation for a move.

Police were called to the couple's residence at 3.00pm and on arrival found the deceased's wife holding her six month old daughter and suffering from several wounds. She told police the deceased had punched her in the face, stabbed her in the abdomen with a pocket knife and then inflicted other cuts with that knife as she tried to shield herself and her daughter. She told police in the initial stages of this attack the deceased screamed twice "*I am going to kill you both".* Police found the deceased in bush land only 50 metres from the house two hours later. He had a number of superficial self inflicted wounds.

The deceased was charged with two counts of attempted murder and appeared the following day in the Warwick Magistrates Court. He was remanded in custody and arrived at AGCC via Toowoomba and Brisbane watch houses on 14 March 2008. This was the first occasion the deceased had been held in custody. In various versions given subsequent to his arrest the deceased did not contest that he had inflicted the wounds on his partner but at all times vehemently denied ever having an intention to kill either her or his child.

In view of the charges, police sought and obtained a domestic violence order listing the deceased as the respondent and his wife as the aggrieved.

Subsequent to his arrest there was reconciliation with his wife who visited him and received phone calls and letters from him while the deceased was on remand.

Medical history and treatment

The deceased first exhibited serious signs of a psychiatric illness in late 2004 at the age of 30. In November of that year he was admitted to the psychiatric ward of the Townsville Hospital following what his mother refers to as a *"nervous breakdown".* The hospital notes indicate a diagnosis of *"acute psychosis*" and a *"long history of poly-substance abuse"* including amphetamines. The psychosis appears to have manifested itself in beliefs that his deceased father was alive and watching his every move. Reference is made to an apparent threat to kill himself and his then wife. Later he stated he had no serious thoughts of acting on this threat. The deceased was prescribed the anti-psychotic drug Olanzapine.

On 8 August the following year the deceased was taken to the Townsville Hospital by his mother and step-father who were concerned about his apparent suicidal ideations. He was admitted for two days and assessment found no evidence of psychosis. The diagnosis was of "*depressive disorder, dependent personality traits and alcoholism".*

Another assessment took place at Townsville on 1 November 2006 when the deceased again presented with suicidal ideation. It was noted at this time that the deceased had stopped taking a previously prescribed anti-depressant, Fluoxetine.

On 28 March 2007 notes from Stanthorpe Hospital show he had taken an overdose of Fluoxetine and Olanzapine while intoxicated on alcohol. He is recorded as having told medical staff he did this with suicidal intent after an argument with his newlywed wife. Over subsequent days he expressed deep regret for the suicide attempt and spoke of two previous suicide attempts, one apparently at age eighteen. After two nights in hospital he was discharged, having been diagnosed with adjustment disorder associated with harmful drug use.

At the time of his being placed in custody at AGCC the deceased was taking Olanzapine although there is evidence he had gone for periods without taking that medication and had not noticed the recurrence of psychotic symptoms.

Mental health treatment after arrest

On 12 March 2008 the deceased was seen by a Court Liaison Service counsellor at the Warwick Watch house who took his psychiatric history and noted his medication.

On arrival at AGCC the deceased underwent a physical examination which was unremarkable. He was seen by a PMHS clinician, Ms Narelle Green, on 17 March 2008. She filled in a section of the "Reception medical history" titled "Social" and ticked a box indicating The deceased should be seen by a psychiatrist although she had not selected the option requiring an urgent consultation. The deceased did not in fact have any contact with a psychiatrist for almost four months when he was seen by Dr Katrina Chiu on 11 July 2008.

However, the deceased's usual medication, olanzapine, was supplied to him from his admission to AGCC.

In addition to the PMHS assessment, AGCC correctional staff also undertook a risk assessment of the deceased when he was admitted to the centre in accordance with their usual practices. As a result of his history and the apparent self-harm shortly prior to arrest the deceased was classified as an "at-risk" prisoner by the risk assessment team assigned to him. This resulted in him being placed on a regime of 30 minute observations by custodial staff until he was next reviewed on 30 March 2008. At that time the frequency of observation was decreased to a two-hourly basis. As no incidents of self harm were observed during this period and as The deceased appeared to be settling into his new surroundings adequately, on 8 April 2008 he was removed from the "at-risk" classification and, consequently, from regular observation. He was placed in the first offenders' detention accommodation section.

On 28 May 2008 the deceased was seen by Mr Dale Ryan, a correctional counsellor after corrections staff had noticed him becoming upset in relation to the contents of a letter from his wife. The AGCC records refer to it as a "Dear John" letter and although it may not have been as final as that would suggest, it likely related the decision of his wife to avoid contact with the deceased at least in the short term.

Mr Ryan arranged subsequent counselling from himself and another counsellor Ms Alison Crowe and several sessions were conducted with the deceased by these correctional counsellors throughout June and July 2008.

Dr Chiu, a PMHS psychiatrist, saw the deceased on 11 July 2008 and 28 July 2008. Her initial assessment was that the deceased showed no signs of psychosis or an active mood disturbance. He denied suicidal ideation. In between these sessions it is clear she devoted a significant amount of time to collating further information on the deceased's background by speaking to his mother, wife, and solicitor amongst others (all with The deceased's consent). She also contacted Stanthorpe police where she was made aware of the DVO and that it included a non-contact order between the deceased and his wife. Dr Chiu was made aware of the possibility the deceased may be released on bail when he next appeared in court on 20 August 2008. As a result she wrote to the Acute Care Team at Toowoomba Hospital and spoke to the District Forensic Liaison Officer, Geoff Argus, as a form of handover of the deceased's case should he receive bail.

In anticipation of his possible release, Dr Chiu placed the deceased on the PMHS Transitions Coordination Program which resulted in him having regular contact with Ms Beverly Church, a PMHS clinician.

Dr Chiu said she felt that the deceased and his wife were down playing the seriousness of his alleged offences. She explained this view and set out her recommended management plan to the deceased when she saw him on 28 July 2008. She says he agreed with the plan but thought it overzealous on her

part. She told him she would arrange for her supervisor, Dr Ed Heffernan to see him to give a second opinion on the level of community care she proposed.

Dr Heffernan saw the deceased on 7 August 2008. He noted psychotic episodes in 2004 and possibly 2006 and that he fulfilled the criteria for schizophrenia as well as alcohol and marijuana dependence. He found there was no need for in-patient treatment and he was content with the medication already prescribed. He agreed with the plan for treatment in the community already recommended by Dr Chiu and in fact made further suggestions on additional treatment measures once The deceased's was released. He saw nothing pointing to any imminent risk of suicide or self harm. The major risk factor noted with respect to the deceased was his exposure to alcohol were he released.

It appears Dr Chiu's contact with Stanthorpe police may have instigated some contact between police and the deceased's wife regarding the DVO. In any event the deceased became aware of this approach by police and attributed it to the actions of Dr Chiu. He told Ms Church he no longer wished to see Dr Chiu. Arrangements were made for Dr Heffernan to become his treating psychiatrist.

On 20 August 2008, the deceased attended court for the committal hearing in relation to his criminal charges. It seems clear, at least in hindsight, that he had built up hopes his charges would be downgraded on this day from attempted murder to unlawful wounding and he may be released on bail. This proved to be incorrect and the deceased was returned to AGCC. In accordance with usual practice in relation to prisoners returning from court, he was seen by reception staff who administered a basic risk assessment screening tool which indicated no increased risk or special needs as a result of the court proceedings.

On 24 August 2008 the deceased refused to accept and take his prescribed Zyprexa. His refusal to take the medication is noted by nursing staff on his medication sheet on both that and the following day. Thereafter the section for that medication remains blank.

Nursing staff appropriately notified PMHS of this decision by the deceased and an appointment was arranged for Dr Heffernan to see him on 28 August 2008. It seems no specific information about the deceased's refusal was passed on to corrections staff although it is noted a custodial corrections officer (CCO) would have been present during both refusals on 24 and 25 August 2008. The CCO having most contact with the deceased throughout late August and early September was CCO Oppermann. He told the QCS investigation that, on reflection, he did recall that the deceased had not been lining up for his medication but thought nothing of it. He indicated he would only place significance on such a thing if nursing staff alerted him to it and any danger it posed.

The appointment scheduled with Dr Heffernan for 28 August 2008 did not take place due to "operational reasons". Dr Heffernan explained that this phrase was often used to explain the myriad reasons in a prison environment (usually due to security arrangements and seemingly not uncommon) as to why a prisoner could not be accessed at a particular appointment time.

Dr Heffernan arranged for the deceased to be seen the following day by a PMHS psychologist Corrine Clifton during her weekly visit to AGCC.

The notes of Ms Clifton show she counselled the deceased against unilaterally ceasing his medication until he had discussed it with Dr Heffernan. Ms Clifton noted that the deceased stated he had stopped taking the drug because "*I don't like lining up"* and "*I don't need it"*. He also apparently told her he was *"thinking clearer*" since cessation of his medication, allowing him to better focus on preparation of his legal defence. The deceased reported being in a "*bad mood*" but suggested this was normal given the unjust nature of the charges pending against him.

Ms Clifton says she saw no clinical signs that caused her concern with respect to the risk the deceased might pose to himself or others. She considered he was exhibiting no signs of mental illness. She was aware a further appointment had been scheduled for the deceased to see Dr Heffernan on 4 September 2008. She did not raise the issue of cessation of medication with anyone at that time being of the view that prison staff were aware (as they had notified PMHS) and that, on her clinical evaluation, Dr Heffernan's follow up appointment was sufficiently proximate for the circumstances.

Events leading to the deceased's death

The deceased's wife attended AGCC on 29 August 2008 for the deceased's 34th birthday. She said that he was looking thin and tired during this visit and he did not tell her he had ceased taking his medication. She said he appeared to be obsessed about the criminal case against him. He told her he couldn't stop thinking about it.

On 31 August 2008 the deceased wrote a lengthy letter to his wife that gives an indication he was entering a period of despair and depression. He appears to cite the visit of 29 August 2008 as a turning point in his mood. He does though discuss the prospects of his wife still being with him after he is released and the possibility he might plead guilty to at least one of the charges.

On 1 September a telephone conversation between the deceased's and his mother lends support to the view he was in a relatively upbeat mood when he saw Ms Clifton. In a recording of the call, the deceased's mother is heard to encourage him to maintain contact with PMHS staff and he tells her not to worry, noting the upcoming psychiatrist appointment. At least in retrospect it is clear The deceased was ruminating on the possibility his charges would not be downgraded and he was coming to the view, rightly or wrongly that he

faced the prospect of putting his wife through a traumatic trial and/or spending many years in prison.

On 2 September the deceased received a visit from his uncle. He reported the deceased to be a bit depressed but this was no different to previous visits and he thought it understandable given the situation he was in. He said he neither saw nor heard anything that made him suspect the deceased might self harm and when he left, the deceased told him he was looking forward to the next visit in 4 to 5 weeks.

CCO Oppermann says the only changes he noted in the deceased in early September 2008 was that he became more engaged in physical activity and was sharing his cigarettes with the other prisoners more regularly. He denied seeing any signs, even in hindsight, that the deceased was contemplating suicide. There is no evidence the deceased disclosed such intention to anyone at AGCC or that he exhibited a change in behaviour that ought to have been noticeable.

Discovery of the deceased's body

The deceased's cell in Unit A1 was locked at 5:25pm on 2 September 2008 with him the only person in it. Evidence tendered at the inquest shows that, thereafter, the cell was not accessed by any person prior to the deceased's death being discovered.

Headcounts were conducted by CCO's on a relatively regular basis throughout the evening and at 1:37am CCO Judith Ilka noted all prisoners she had checked, including the deceased to be present and with nothing to report.

During the next headcount at 3:52am CCO Ilka observed the deceased in bed with a cover of some sort over his face. She got no response from him by knocking on the door of his cell so called to her colleague CCO Sarah Forsyth. CCO Forsyth says she thought the deceased's had a plastic bag over his head and suggested they call for "Romeo 3", code for the on call corrections manager. This was necessary to obtain permission to open the cell. It seems after this call was broadcast, a "Code Blue" signifying a medical emergency was also called.

Corrections Manager Peter Henderson was "Romeo 3" on that shift and he made his way to Unit A1 from another section of the prison. The running log records him arriving at 4:00am but the cctv recorded vision indicates he arrived at 3:57. He said by the time he arrived the key to the deceased's cell had been obtained from the officers' station and he immediately gave permission to open the door. Mr Henderson was the first to enter the cell and saw the apparently lifeless body of the deceased with a plastic bag over his head, secured with a cord around his neck. He unsuccessfully checked for a pulse before rolling the deceased onto his back to get a better view. He said in his statement:

> *I was about to take the bag off and to start CPR, when medical staff arrived with all the equipment and took over from me.*

In fact the cctv recorded vision shows that the nurses, Stephanie Luffman and Joanne Harty, arrived at the cell a little over four minutes after Mr Henderson. Both say in their statements that the plastic bag was still covering the deceased's head when they went into the cell.

The nurses took over the treatment of the deceased, removing the bag from his head, moving him onto the floor and attaching a defibrillator. That machine indicated CPR should be continued as no shockable rhythm was detected.

An ambulance was called with QAS records showing receipt of a telephone call at 4:01am. QAS arrived at AGCC at 4:19am but paramedics were delayed by eight minutes getting through security before arriving at the deceased at 4:27am. Their notes are consistent with the version of prison staff that CPR attempts had continued up until that point and only ended at 4:30pm when one of the paramedics declared an "obvious death". It is now sadly evident no measures taken from the time he was discovered could have revived the deceased.

Notification of next of kin

The general manager of AGCC at the time was Mr John Myers. He was notified of the death by telephone soon after 4:00am and made his way to the centre arriving at 4:35am. He gave evidence at the inquest to the effect his first order of business was to ensure the maintenance of security and good order at the prison. In addition to overseeing this he was involved in briefing senior QCS officers, the QCS media liaison officer and managers of his employer GEO Pty Ltd. He was required to ensure appropriate resources would be available on the upcoming day shift to deal with the extra requirements that come with a death in custody. He also participated in staff debriefings noting nursing staff in particular were distressed by the death of the deceased and their lengthy, but unsuccessful, attempts to revive him.

He did not make contact with any of the deceased's family until he called his mother shortly before 10:00am.

Earlier in the morning The deceased's wife had heard a radio news bulletin stating that a 34 year old man on remand for attempted murder had been found deceased at AGCC. This is consistent with the contents of a QCS media release issued at 7:44am. Fearing it was the deceased, his wife immediately contacted his mother who in turn contacted Stanthorpe police. They confirmed the deceased had died and advised a police vehicle was on the way with officers who had been briefed to pass on this information.

When the deceased's mother received the call from Mr Myers she was naturally upset and has complained of what she considered to be an inappropriately curt and uncaring tone. Mr Myers denied this saying one of the reasons for the timing of his call was the period he spent considering his words for what was always going to be a difficult call.

The family of the deceased are understandably upset they were first notified to the death of their loved one via a radio news bulletin albeit one that did not identify him directly.

Autopsy results

An external autopsy examination was carried out on 4 September 2008 by an experienced forensic pathologist, Dr Beng Ong. A blood sample was taken and sent for toxicology testing. After considering the results and his observations, Dr Ong issued an autopsy report which included the following findings:

> *The post-mortem examination showed presence of hypostatic congestion on his face. A few fine petechial haemorrhages were present on the right conjunctiva. These are non-specific haemorrhages which could be related to the tying of cable around his neck. A faint incomplete ligature mark was present on the neck and would be consistent with stated history of a cable being tied around his neck.*
>
> *There are marks of therapy present. No further injuries could be elicited.*
>
> *The toxicology analysis did not detect any drugs or alcohol.*

Dr Ong listed the cause of death as:

> *1(a). Consistent with plastic bag asphyxia*

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.

Identity of the deceased –	The deceased person's identity is not disclosed for the reason set out on the first page of these findings.
How he died -	The deceased intentionally took his own life by asphyxiating himself with a plastic bag while he was in pre-trial custody.
Place of death –	He died at the Arthur Gorrie Correctional Centre, Wacol in Queensland.
Date of death –	He died on 3 September 2008.
Cause of death –	The deceased died from asphyxia.

Conclusions on issues

There were a number of contentious issues examined at the inquest. My findings, and where necessary, preventative recommendations in relation to them are as follows.

Was any other person involved?

There is no evidence any other person was causally involved in the deceased death. I conclude he intentionally ended his own life after despairing at the thought of serving a lengthy prison sentence and the prospect of his relationship with his wife ending, resulting in his having limited contact with his children.

Was the suicide foreseeable?

When he was visited by his uncle on 2 September, The deceased was understandably unhappy but there is no evidence he had by then already determined to end his life. Similarly, his wife who saw him on 29 August and his mother who spoke to him on 30 August did not detect him to be at risk of self harm. Such decisions are often impulsive or impetuous and even those close to the dead person are caught unawares. In the circumstances prison staff could not have been expected to have realised the deceased was at risk. I find none of the correctional officers or inmates at AGCC caused or contributed to the death and, under the circumstances, nothing could have been done by those people to save the deceased.

Quality of mental health care at AGCC

It is apparent there was an unacceptable delay in the deceased being seen by a psychiatrist after he arrived at AGCC: nearly four months elapsed. The Director of PMHS, Dr Andrew Aboud candidly acknowledged this had occurred as a result of administrative arrangements not keeping pace with the growth in the service's patient population. I accept his assurances changes involving individual psychiatrists being given more control over their patient list and appointment bookings have addressed the issue.

I also accept that apart from this initial glitch, the quality of care given to The deceased by the PMHS was of a high standard. It was responsive to his needs and concerns and proactive to possible changes to his circumstances.

Did the cessation of medication contribute?

The deceased had been taking an antipsychotic medication, olanzapine, intermittently for four years prior to his death. It was continued when he was admitted to the AGCC but he stopped talking it 14 days before his death. The inquest received considerable evidence as to whether that may have caused a change in his mental health sufficient to contribute to his decision to end his life.

The deceased was reviewed by a clinical psychologist 6 days after he stopped taking the drug. She detected no signs of any thought disorder or depression. He told her he was thinking more clearly and did not disclose any negative effects. As detailed earlier, the three family members that had

contact with him in the following few days, likewise detected no signs of re-emerging psychosis or depression.

Dr Jill Reddan, an experienced consultant psychiatrist, advised that in her experience with her patients and as a result of her familiarity with the relevant literature, she considered the risk of self harming did not increase in the period immediately after the drug was discontinued.

She also considered there was nothing in a letter to the deceased's wife dated 31 August 2008 that suggests The deceased was morbidly depressed, or suffering from a melancholic depression, had reached a point of despair or had given up on life. Dr Reddan believes that, to the contrary, the content of this letter suggested the deceased was future oriented.

The inquest heard from Dr Andrew Aboud, Director of PMHS who stated there was no established link between sudden cessation of olanzapine and an increase in suicidal thoughts or tendencies.

The cessation of olanzapine can be associated with a return of psychotic symptoms but there is no evidence it occurred in this case. I conclude that the discontinuation of the drug played no part in the deceased death.

The response to the cessation of medication

When the deceased ceased taking his prescribed psychotropic medication, a nurse advised the PMHS clinical co-ordinator at the AGCC who arranged for him to be seen by a psychiatrist a few days later. When that doctor was unable to see the deceased as planned, arrangements were made for him to see a clinical psychologist the following day. As detailed earlier that health worker, Ms Clifton, sought to persuade the deceased to resume taking his medication but also satisfied herself the discontinuance of it had not negatively impacted on his immediate mental health and he needed no extra or other treatment for his underlying condition. She confirmed with him that he would have on-going contact with the PMHS and noted his treating psychiatrist was scheduled to see him in under a week.

I am of the view Ms Clifton took all appropriate action in relation to the deceased's immediate and on-going mental health needs. She did so even though the response to such a situation was not the subject of any policy or documented procedure. That has now been remedied.

Ms Clifton reported the results of her review to the PMHS clinical co-ordinator but custodial staff were not formally advised that The deceased had ceased taking his medication.

It was submitted at the inquest that there might be benefits from alerting custodial staff to be particularly vigilant in monitoring the behaviour of prisoners in such situations. Against this it was submitted that the breach of the patient's privacy was not justified and custodial staff should continue to be encouraged to monitor all prisoners to note and react to any change of behaviour, from any cause.

I accept this counter argument.

Was the response to the death appropriate?

Initial response

It took almost 10 minutes from the time the deceased was noticed to have a bag over his head until that danger was neutralised. Part of that delay was the result of the policy of the prison to prohibit cells being opened at night without the authority of the Shift Supervisor and the presence of three officers. The rest of the time was due to the failure of the Shift Supervisor to remove the bag from the deceased's head after he entered the cell.

QCS policies in place at the time required first response officers to commence emergency resuscitation unless there is clear evidence life is extinct. Mr Henderson was not able to explain his inaction because apparently he did not recall it. I assume it was a result of his conclusion the deceased was dead and beyond help. On this occasion he was correct but it was a dangerous assumption for a person with no medical training to make.

Current policies now require an apparent death to be treated as a medical emergency requiring the commencement of life saving measures unless and until health staff advise otherwise.

Notification of the death

As detailed earlier, nearly six hours elapsed between the time of the death being discovered and the deceased's mother being advised of it by the centre's general manager, Mr Myers. In the intervening period a media release had caused to be broadcast over commercial radio sufficient information about a death in the AGCC to enable the deceased's wife to correctly conclude it probably related to him.

The policies in place at the time required the general manager to notify the deceased prisoner's contact person as soon as possible, *"subject to operational requirements."*

Mr Myers initially sought to suggest operational demands had prevented him from calling the deceased's mother sooner. Faced with the fact he had found time to discuss the death with the QCS media section, he conceded this was not the case.

I find that Mr Myers did not give the call sufficient priority. The call should have been made much earlier than it was.

I accept that in a prison environment, news of a death will often spread rapidly and before long be conveyed to people outside the centre by unofficial sources. In the interests of transparency, accountability and accuracy and to assure the public the death will be independently investigated, it is appropriate the QCS make a timely media release about the death.

However, no information which could enable a deceased prisoner's contact person and next of kin, should be released until reasonable attempts have been made by the responsible officials to contact them.

Currently, there is no requirement for the QCS media section to defer issuing a media release until it is advised this has happened. Counsel for QCS indicated his client was prepared to give an undertaking to the court that an instruction to this effect would be given and no recommendation was therefore necessary. With all due respect to those currently in the relevant positions, I am familiar with the rate at which senior correctional and media staff members relocate and conclude something more formal is required.

Recommendation 1 – Publication of death in custody information

While recognising the genuine public interest in the publication of information about deaths in custody, this must be balanced against the distress that can be caused to those close to the deceased if they first hear of the death via the news media. Accordingly, I recommend QCS media section policies be amended to stipulate that before a media release is issued in relation to such an event, the responsible officer establish whether the deceased prisoner's contact person and next of kin have been advised of the death. If not, no information that is likely to enable those persons to identify the deceased prisoner should be included in a media release until all reasonable efforts to do so have been undertaken .

Contact between prisoners and others

The deceased's wife was the aggrieved named in a domestic violence order prohibiting the deceased from having any contact with her. She was also obviously a victim of the serious crimes alleged against him and the principle prosecution witness.

Despite this, while on remand at the AGCC he was able to write to her, make telephone calls to her and receive visits from her. No adequate explanation of this was provided to the inquest by either QCS or GEO.

Recommendation 2 – Review of contact controls

It will rarely be appropriate for an accused person who is the respondent to a domestic violence order and who is in custody to have contact with the victim of his/her alleged crimes or the aggrieved person named in the DVO. QCS policies should require all correctional centres to have in place procedures to ensure this only occurs after a fully informed and considered decision to allow it is made and such contact as is permitted is not contrary to the terms of the DVO. I recommend QCS review its policies to ensure this occurs.

Time of evening meds round

As I understand the arrangements in place in most correctional centres, the regular administration of prescribed medication occurs during two rounds: one in the morning and one in the afternoon. This suits the convenience of the centres as more nurses and custodial corrections officers are rostered to work during daylight hours.

Dr Aboud, the director of the PMHS, is firmly of the view that optimal health care for a significant number of the patients of his service would be better served if they were to receive their medication later in the evening as occurs in most psychiatric wards. He cited theoretical, empirical and research evidence to support that view.

QCS is committed to the equivalence principle in health care which requires, so far as is practically possible, that prisoners receive an equivalent standard of health care as other members of the community.

I was urged by counsel assisting to recommend QCS investigate why this should not include an evening medication round. Counsel for GEO submitted I had neither jurisdiction nor an adequate evidential basis on which to do so.

In *Doomadgee & Anor v Deputy State Coroner Clements & Ors*[2], Muir J rejected the suggestion that s46 comments could only be directed at preventing deaths from occurring in circumstances similar to those of the death under investigation; indicated s46 should be construed liberally and pointed out there was no basis to read the term in the section "*connected with*" as only meaning "*directly connected with*."

There is no doubt the subject of the proposed comment relates to public health and safety. Further, in my view it is connected with the death in question to the requisite degree in that before he ceased taking the medication, the deceased was receiving it at what according to Dr Aboud was a less than optimal time of the day and it was apparently negatively impacting upon his clarity of thought. Accordingly, I consider I would have jurisdiction to make a s46 comment directed to the issue.

I hesitate to do so however for the second of the reasons raised by counsel for GEO, namely, because it was not identified as an issue early in these proceedings, neither GEO nor QCS had an opportunity to seek instructions or produce evidence about the practical ramifications of such a change. In the circumstances, I believe it would be inappropriate for me to make any recommendation.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
14 October 2011

[2] [2005] QSC 357 para 29, 30, 33