QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Lawrence McCarty**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/1456
DELIVERED ON:	18 April 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	18 December 2012, 3 – 5 April 2013
FINDINGS OF:	Michael Barnes
CATCHWORDS:	CORONERS: Inquest – death in custody, suicide, use of razor blades in prison, adequacy of medical care, adequacy of supervision of prisoners

REPRESENTATION:

Counsel Assisting:	A Martens
The GEO Group Australia Pty Ltd:	J Rosengren (instructed by Ashurst)
Department of Community Safety:	K Philipson (instructed by Department legal unit)
Dr Hussain:	M Zerner (instructed by K&L Gates)

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Introduction

Lawrence McCarty had been in custody on remand for just over two months at Arthur Gorrie Correctional Centre (AGCC) when, at approximately 11:15am on 30 April 2011, he was found deceased in his bed. Mr McCarty appeared to have slashed his throat using a dismantled razor.

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;
- consider the adequacy of the medical care provided to Mr McCarty;
- consider the adequacy of the practices and procedures in place at AGCC in relation to the possession of items that could be considered or used as dangerous weapons;
- consider the adequacy of the practices and procedures in place at AGCC to conduct headcounts and/or welfare checks on prisoners;
- consider the adequacy of the interviews conducted with the prisoners by the Queensland Police Service following Mr McCarty's death; and
- consider whether further investigation could have occurred to determine the time of Mr McCarty's death.

The investigation

Detective Senior Constable Brendan Anderson from the QPS Corrective Services Investigation Unit (CSIU) investigated the death and produced a report which was tendered at the inquest. He attended AGCC and examined Mr McCarty's cell; observing the body in situ. Forensic examination and photographing of the cell and Mr McCarty's body occurred. Detective Senior Constable Anderson and other officers from the CSIU conducted interviews with other prisoners in the unit housing Mr McCarty and took statements from custodial corrections officers (CSO's) and some of the medical staff at AGCC.

A parallel investigation into the death was ordered by the Chief Inspector of Queensland Corrective Services. Two inspectors compiled a detailed report of their findings which was also tendered at the inquest. I found this investigation and report to be thorough and most helpful in framing issues for consideration at the inquest.

In aggregate I found the two investigations to have addressed all relevant issues, other than examining the issue of the provision of razors to prisoners, and to have sourced all relevant information.

Further statements addressing issues that were identified at the pre-inquest conference were obtained and provided by legal representatives representing the various parties who were given leave to appear at the inquest.

The Inquest

A pre-inquest conference was held in Brisbane on 18 December 2012. Ms Martens was appointed as counsel to assist me with the inquest. Leave to appear was granted to Queensland Corrective Services (QCS), GEO Australia Pty Ltd (the operator of AGCC) and Dr Hussain.

An inquest was held in Brisbane on 3, 4 and 5 April 2013. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Sixteen witnesses gave oral evidence.

The evidence

Personal circumstances

Lawrence McCarty was born on 6 January 1966 in Brisbane. He had a relatively lengthy criminal history and had been imprisoned for over 20 years over the course of his life.

Mr McCarty was the father of twin daughters with whom he did not have much contact. Prior to being arrested, Mr McCarty had been focusing on securing regular contact with his daughters and developing some skills to try and enter the workforce. There is some evidence that Mr McCarty had indicated to some family members and his general practitioner that if he were to return to custody he would kill himself. There was no evidence that this information had been conveyed to correctional, medical and/or nursing staff at AGCC.

On 18 February 2011, Mr McCarty was arrested and charged with the armed robbery of a chemist on 11 February 2011. Mr McCarty was detained in the Southport watch house. When Mr McCarty was admitted to the watch house, a number of health related questions were asked. Mr McCarty denied currently seeing or having ever seen a psychiatrist, claimed he had never attempted suicide or self-harm in the past and had never had thoughts of suicide or self-harm now or in the last three months.

Mr McCarty appeared in the Southport Magistrates Court on 19 February 2011, bail was opposed and Mr McCarty was remanded in custody. On 23 February 2011, Mr McCarty was transferred from the Southport watch house to AGCC.

During his last period of incarceration at AGGC, Mr McCarty was considered by staff to be a model prisoner who did not seek to actively engage with correctional staff. He was described universally as a quiet prisoner who was an avid reader. No-one was able to identify any possible enemies of Mr McCarty. Several prisoners indicated that Mr McCarty was friendly and shared his possessions with other inmates when requested.

Prison medical history

Mr McCarty's medical file at AGCC comprised of two volumes.

On numerous admission and transfer documentation, Mr McCarty was asked about mental health history, suicide and self-harm attempts and views. Generally, on more than 12 occasions between 1990 and 2006 he denied any such history.

Of relevance, his records reveal:

- he had been diagnosed with depression in 1991;
- he advised staff he was slightly depressed in 1994;

- he stated he was seeing a psychologist or psychiatrist in 2002 and 2003;
- he advised he had mental health problems in 2003; and
- twice in 2003, Mr McCarty stated he had depression from chronic pain

In February 2006, the Capricornia Correctional Centre obtained Mr McCarty's medical records from a general practitioner in Toowoomba and in Mackay. The records from Toowoomba reveal that in early 2003 Mr McCarty had been diagnosed with depression and then anxiety and treated with Zoloft. The records from Mackay reveal that in late 2004 Mr McCarty was taken to hospital with a self inflicted laceration to his left arm and had taken his medication in an overdose attempt. Within a few weeks, Mr McCarty was noted not to be suicidal anymore. There is also a letter from Dr Atkinson who noted that Mr McCarty had an adjustment disorder of the depressive type.

On 17 December 2007, a Medical in Confidence, reception medical history was completed and Mr McCarty advised he was seeing a psychiatrist for pain. As a result of the assessment, Mr McCarty was referred to a psychiatrist in relation to his prescription of Zoloft and referred to a psychologist and counsellor.

On 28 December 2007, Mr McCarty underwent a client intake and initial assessment with the Prison Mental Health Service. It was noted that Mr McCarty's referral was due to the fact he was on Zoloft 200mg and seeing a psychiatrist privately. No psychotic symptoms were elicited. Mr McCarty denied any past suicide attempts and no current suicidal/homicide ideation. The referral also noted Mr McCarty saw a psychiatrist, Dr Graeme Rice for chronic back pain. The plan was to close the file and advise Mr McCarty to refer back to mental health services if his mental health state changed.

Out of prison medical history

Mr McCarty attended upon psychiatrist, Dr Graham Rice from 2001 until 15 May 2008. The notes reveal that Dr Rice was treating Mr McCarty in relation to his pain. The last notation in July 2008 records that Mr McCarty's future consultations would be cancelled and no further consultations allowed as Mr McCarty had changed the dates on the scripts which Dr Rice had provided. Contained within Dr Rice's records is a letter from a general practitioner in Mount Pleasant, Dr Charnley who on 13 September 2004 expressed dismay at Mr McCarty's progress, that Mr McCarty had wild swings in Oxycontin usage and there were quite a few implausible stories regarding lost scripts/tablets. Dr Charnley noted that Mr McCarty had 'expressed some parasuicidal thoughts recently'. There is also a record from a consultation on 29 September 2004 that if Mr McCarty could not do something about the pain then he swore he would kill himself. Dr Rice's records also contain the discharge summary from Mackay Base Hospital on 2 November 2004 following Mr McCarty's suicide attempt. The summary notes that a psychiatric evaluation was undertaken as Mr McCarty could not guarantee his safety if discharged. Mr McCarty was prescribed Mirtazapine, Diazepam and ceased Doxean. Mr McCarty was referred to community mental health.

Dr McIntosh's full medical records were obtained. Dr McIntosh noted in correspondence on 7 January 2005 that Mr McCarty's drug use was absolutely consistent with the prescribed dosages and his relationship had stabilised which was one of the causes of Mr McCarty's self harm episode. Dr McIntosh noted Mr McCarty had become more stable emotionally. Dr McIntosh's records also contained the correspondence from Dr Charnley and the discharge from the Mackay Base Hospital.

Dr McIntosh's records also contained a dual assessment form from Mackay Mental Health Service from 9 November 2004. The assessment noted that Mr McCarty had been commenced on anti-depressants on 2 November 2004 and that at the time of his suicide attempt he had been drinking heavily and misusing morphine. The current psychiatric diagnosis was depression due to not working, poor relationship, drug and alcohol problems and chronic pain. Mr McCarty reported that after his suicide attempt and being commenced on anti-depressants and detoxing from drugs and alcohol, his mood had improved. The plan was to refer Mr McCarty to a pain clinic, for Dr McIntosh to manage Mr McCarty's medication and for Mr McCarty to continue relationship counselling at Relationships Australia.

From August 2007 up until his arrest, Mr McCarty appeared to have been treated by GP, Dr Neal Jones. His records reveal prescriptions, at different times, of Oxycontin, Murelax, Champix, Panadeine Forte, Tramal, Nexium and Fentanyl patches. Zoloft had been prescribed to Mr McCarty on previous occasions during this period. The last prescription for Zoloft had been on 24 September 2010 which ceased on 28 January 2011.

Induction and medical treatment

QCS Assessment Procedure states that should staff become aware of such information, it is required that a self-harm episode (history) offender warning flag be entered in relation to the prisoner on IOMS. Further, the existence of such a matter may trigger further assessment by psychological staff. There was no such flag for Mr McCarty.

Upon reception at AGCC, an inmate must undergo a medical examination by a suitably qualified health professional within 24 hours of being received and thereafter as necessary. Whilst Offender Health's procedures do not specifically require a review of an inmate's medical records, best medical practice dictates that, where relevant and available, a patient's medical records are considered as part of the patient's treatment plan. The procedure manual on New Receptions notes that an offender who has been identified through the assessment process as having a mental health problem or a previous history of mental health problems will be offered a referral to Prison Mental Health Services (PMHS).

Upon reception at AGCC on 23 February 2011, Mr McCarty underwent an Immediate Risk and Needs Assessment which was completed by Greg Cameron on 23 February 2011. He noted that Mr McCarty had denied any history of self-harm/suicide attempts or ideation and denied any current suicide/deliberate self-harm ideation.

RN Karena took a brief medical history and completed the medical alert form, completed the blood testing/immunisation record and completed the health management plan. In the Health Management Plan, there is a question 'have you been seen by a psychologist or psychiatrist in the community?' Mr McCarty responded: 'Yes, Dr Graeme Rice, Wickham Terrace.'

There was different evidence about what further information, if any, should be obtained from a prisoner making such a disclosure. EEN Shilton says that on the face that would warrant an automatic referral to PMHS because it suggested ongoing issues in the community. RN Karena says she would not clarify any further information, particularly if it was parole-ordered, but depending on the prisoner's presentation she would leave it for the doctor to consider. Dr Hussain stated he

would make some enquiries with the prisoner about why they were seeing a psychologist or psychiatrist.

EEN Shilton undertook the reception interview with Mr McCarty on 23 January 2011. Mr McCarty's medical records were available and reviewed by EEN Shilton. She says that her normal practice when reviewing the medical records is to scan the available records, she does not read the records line by line. Essentially, she would look for significant past medical complaints that have not been reported by the inmate at the time of the assessment, including episodes of self-harm, mental illness etc, or otherwise look for confirmation of the reported history as given by the prisoner. Previous medication is of interest if the patient requires medication to manage a condition. On the proforma, EEN Shilton noted that Mr McCarty did not have any history of a psychiatric/mental health disorder. Given Mr McCarty's previous history of depression, she conceded she should have selected 'yes' to this question.

On all the documentation completed by EEN Shilton, Mr McCarty denied any previous self-harm or suicide attempts. Mr McCarty did advise that he had depression as a result of pain from injuries and had been on anti depressants in the past. EEN Shilton's action was to refer Mr McCarty to the Visiting Medical Officer (VMO) in relation to his chronic pain.

EEN Shilton says that if she had been aware of Mr McCarty's previous self-harm attempt she would have explored this further with Mr McCarty and sought advice from a registered nurse.

On 24 February 2011, Mr McCarty was reviewed by Dr Hussain. Dr Hussain noted that Mr McCarty had fractured his C1 – C3, C6 and C7.1 17 years ago and had previously been on Durogesic and before that Oxycontin. On examination, Dr Hussain noted that Mr McCarty was 'stable, vitals, walked in, looked in pain and distressed'. Dr Hussain noted no weakness in Mr McCarty's upper limbs. Dr Hussain detailed that his treatment was Tramal 100mg twice daily after signs and symptoms of withdrawal ceased but not before 3 March 2011 and Naprosyn 500mg once daily as required. Dr Hussain noted he would review Mr McCarty when required.

Dr Hussain indicated that if he had been aware of the previous self-harm attempt then he would have asked Mr McCarty about this issue and the circumstances in which it occurred.

The final page of the medical in confidence document would normally be completed. Dr Hussain indicated it was his normal practice to complete this however he could not explain why on this occasion he did not.

The medical charts record that Dr Hussain prescribed Tramal slow release 100mg BD orally after 3 March 2011, Naprosyn 500mg twice daily orally as required and Zoloft 100mg once per day in the morning orally to commence on 25 March 2011.

Dr Hussain did not specifically refer to the prescription of Zoloft in the progress notes he made. Whilst he has no independent recollection of Mr McCarty's assessment or prescriptions, Dr Hussain believed that he prescribed Zoloft because he had been informed of Mr McCarty's significant orthopaedic injuries and Mr McCarty's need to take medication to respond to the pain associated with those conditions; it was probable Dr Hussain had been informed Mr McCarty had been taking Zoloft at a dose

of 100mg daily prior to his admittance and Mr McCarty had been prescribed Zoloft and Tramal during his last incarceration.

Dr Hussain says he is confident that prior to prescribing Zoloft to Mr McCarty, he would have been satisfied that Mr McCarty had taken Zoloft prior to his admission to AGCC and that Mr McCarty was not suffering or displaying any symptoms of acute depression because:

- unless the patient is taking anti-depressant medication to good effect, Zoloft is not a medication that is Dr Hussain's usual and routine practice to prescribe because there are more effective serotonin uptake inhibitors available;
- at AGCC Dr Hussain would not commence an inmate on anti-depressant medication who has not previously taken anti-depressant medication but instead refer the inmate to the mental health team for assessment;
- at AGCC if an inmate presents feeling depressed or low in mood Dr Hussain would refer the inmate to the mental health team for immediate assessment and specialty risk assessment for self-harm for the inmate to speak to the counsellor in order to obtain details of the inmate's mental health history; and
- whilst it was not his usual or routine practice to prescribe Zoloft for the first time however if he were, Dr Hussain would commence a patient on either 25mg or 50mg and then titrate up the dose.

Mr McCarty was reviewed by Dr Pham on 14 and 18 March 2011. The first review appears to have been in relation to Mr McCarty's back pain following a fall from a chair in the unit and the second occasion because Mr McCarty had submitted a request to a nurse with 'bad headaches from eyes'. There is no note that records any review of Mr McCarty's prescription of Zoloft. Dr Pham says there were no signs or indications of concerns in relation to Mr McCarty's mental health and no cause for review of Mr McCarty or the prescription of anti-depressants. Dr Pham was unaware of the previous entry in 2004 to a self harm incident however he stated he would not have made any changes to his treatment had he been aware of this information.

The medical and nursing witnesses were asked about the treatment for depression. RN Karena indicated that Mr McCarty should not have been referred to PMHS because there was no suggestion Mr McCarty's depression was acute; he had reported his depression was second to chronic back pain; he had been referred to the VMO for treatment and in the community this would be generally treated by a General Practitioner and because PMHS had specifically instructed nurses at AGCC not to refer prisoners where their mental health issues were limited to anxiety and/or depression. EEN Shilton indicated that a prisoner with depression would not automatically be referred to PMHS, it would depend on other factors including the prisoner's presentation. Dr Hussain and Dr Pham agreed that the treatment of depression, with no other complicating features was for the VMO to treat. Dr Hussain indicated that his general practice was to enquire of the witness their ability to cope and if he was satisfied that their presentation was consistent, he would treat them. If he had any concerns he would refer the prisoner to mental health services.

No referral for Mr McCarty was made to mental health services.

Dr Hussain stated that at AGCC there was no ability to schedule follow up appointments for inmates, like there would be in the community, because he could not be sure when he would next be at AGCC working as a VMO. Dr Hussain noted that in the prison environment however, prisoners receiving medication would see a nurse twice a day and have ready access to medical attention if they required it. There was also the benefit of having CSO's who were with the prisoners daily to

identify any concerns. Finally, there was the opportunity when the prescriptions were being re-issued, if a prisoner had not been reviewed in some time, to arrange for the prisoner to be reviewed. It would appear that, unlike in the community where patients must return to a GP for a new prescription when the prescription ran out, in the prison environment there is the potential for prescriptions to continue indefinitely without a review.

Dr Pham indicated he had a practice, if he wanted to follow up prisoners, to make an entry in his diary or communications book to arrange for a CSO to have the prisoner returned for a review. The other opportunity was when prescriptions were being re-written.

Dr Pham and Dr Hussain indicated that implementing a process of a regular review, either after a fortnight or month, of prisoners on anti-depressants would result in a significant increase to the VMO's workload.

Medication rounds

From 24 February until 20 April 2011, Mr McCarty was noted to have been prescribed Tramal SR 100mg at 0800 and 1600, Naprosyn 500mg at 0800 and 1600, Zoloft 100mg at 0800. Tramal commenced immediately, despite Dr Hussain's order.

The medical records show that while there were a couple of occasions where Mr McCarty did not take all of his prescribed medication, the only day he did not take any of his medication was on 8 March 2011. Mr McCarty last consumed medication on the afternoon round on 29 April 2011.

At the time, the practice adopted at the medication rounds was to announce the round and allow prisoners to attend to collect their medication. A prisoner would only be sought to attend to receive their medication if they were taking essential medication. The nursing staff all considered that Mr McCarty's medication was not essential. Medication round practice has since changed and the practice is now to require all prisoners to attend the round, regardless of whether the medication is considered to be essential or non-essential so that a refusal to receive medication can be noted as is required by the Provision, Supply and Administration of Pharmaceuticals procedure manual. Other than the administration of Clozapine which requires immediate notification, action is only to be taken by referring a prisoner to a medical practitioner if they refuse medications for three days.

Staff who dispensed medication to Mr McCarty in the last week of his life were asked to provide details regarding the dispensation of medication. They all confirmed that the procedures adopted to ensure prisoners did not stockpile medication (i.e. checking medications swallowed, hands empty) were undertaken with respect to Mr McCarty.

It was the opinion of Dr Hussain, and Dr Griffin who provided an expert report, that Mr McCarty suffered from severe pain and if he had not been taking his medication, and had stockpiled it, there would be evidence of this within a day or two. Mr McCarty would appear to be in pain and potentially behavioural changes would be observed. No such changes were observed by CSO's or fellow prisoners.

Despite all the opportunities that were presented to Mr McCarty when attended by medical and nursing staff, at no time did he report any concerns of depression or any self-harm ideation, nor were there any complaints or observations that his chronic pain had not been adequately addressed or managed.

Disposable razors in Unit C5

Mr McCarty was housed in cell 19 in unit C5. His cell was located on the ground floor of the unit. As Mr McCarty was housed in mainstream accommodation (as opposed to the Maximum Security Unit) and not considered to be an 'at-risk' prisoner he received an annual allocation of disposable razors and toothbrushes. Such items are allowed to be kept by the prisoner in their cell as part of their personal property. Any razor blade which was removed from its plastic mould casing for an illicit or forbidden purpose, e.g. fashioned into a weapon, or even just removed and hidden, would be considered a 'prohibited thing' and confiscated.

A number of CSO's gave evidence regarding the dismantling of razors in mainstream accommodation. One CSO indicated a dismantled razor would be located once a shift, another indicated two – three times every two weeks. There is no clear data other than Mr McCarty is the second death as a result of a dismantled razor in five years. There was no readily available evidence as to how frequent or infrequent razors have been used in self-harm attempts, to commit violence towards other prisoners and CSO's or simply used for other means such as lighting cigarettes and completing artwork.

The provision of razors to at-risk prisoners or to prisoners contained in the Maximum Security Units is tightly controlled. In these units, prisoners are either observed shaving and required to return the shaver or are provided with electric razors.

A cell search is conducted by two CSO's and involves a very thorough search of the cell. One of the primary purposes of such a search is to ensure there are no prohibited items in the cell. Medications and dismantled razors are considered prohibited items and removed if discovered. The last cell search conducted on Mr McCarty's cell was on 9 April 2011, and nothing was recorded. The entire unit was subjected to cell searches on 13 April 2011 and nothing of note was recovered from Mr McCarty's cell.

The purpose of a cell inspection is to ensure the cleanliness and hygiene of each cell. In ensuring that a cell is clean and in order, a general check for prohibited items is also conducted. Mr McCarty's cell was inspected on 10 and 24 April 2011. Again, no prohibited items were located.

Events preceding the death

Many of Mr McCarty's fellow prisoners and some of the CSO's were able to recall Mr McCarty's routine in the morning. He would leave his cell at breakfast time; obtain his medication and then return to his cell at the 0830 lockaway until the 1100 muster. CSO Fibbes accepted that this was Mr McCarty's routine. CSO Lawson was adamant about this routine to the point that he said he would have checked on Mr McCarty if he departed from this routine.

Mr McCarty had case notes completed on 22 and 24 February, 4, 6, 13, 14 and 16 March and on 26 April 2011. The case notes on 13 March 2011 indicate that Mr McCarty had been housed in the medical unit and he had not shown any signs or indication of self harm while staff had been on duty over the weekend. The final case note on 26 April 2011 was completed by CSO Lewis and noted that 'Prisoner McCarthy a mature aged prisoner who mixes with prisoners his own age, he only comes to the officers station if he needs anything but is respectful towards staff. He appears to get along with his peers and has no known issues at this time when asked by the unit staff.'

Mr McIntyre, a fellow prisoner, was of the opinion Mr McCarty was depressed. Approximately a week before Mr McCarty's death, upon request, Mr McIntyre provided Mr McCarty with a yellow razor. Mr McCarty disclosed he had finished serving ten years for armed robbery and when he was out he took illegal drugs and committed the same offence. Mr McIntyre's opinion was based on two – three conversations with Mr McCarty. Mr McIntyre did not pass on his observations of Mr McCarty to any other prisoner or CSO. Prisoners who had known McCarty for longer, indicated to police that they had not observed any changes in his demeanour or attitude. However, prisoners Jackel and Monseen mentioned that on the evening of 29 April 2011, Mr McCarty had stated he was not feeling well. None of the prisoners interviewed could recall Mr McCarty exiting his cell on 30 April 2011.

Mr Sebez, another prisoner, told inspectors that Mr McCarty was a reserved person who kept to himself. He stated that Mr McCarty was a 'deeply depressed guy' who always had a forlorn look. However Prisoner Sebez did not believe that the prisoner's mood had noticeably changed prior to his death. Prisoner Sebez was not in unit C5 on 30 April 2011. It is unknown when he left C5.

CSO Lawson was the CSO on duty on the evening of 29 April 2011, who locked down all the inmates in C5. Mr McCarty was observed on the video footage entering his cell and closing the door at 16:42. CSO Lawson was adamant that he would use the muster book to do a face to photo lockaway. His practice, if he could not see the prisoner, would be to go into the cell and ask if they were alright.

Throughout the evening, four headcounts were conducted at 20:30, 23:36, 01:45 and 04:02.

CSO Fibbes and CSO Lewis were on duty in unit C5 from 06:30 to 18:30 on Saturday 30 April 2011. CSO Fibbes says that her duties as the 'unit officer' were to complete the morning head count, unlock, cell access, monitoring the welfare of inmates, conducting musters and cell searches. She remained in the unit whereas partner CSO Lewis remained outside the unit monitoring CSO Fibbes and maintaining the bookwork.

At 06:50 the log notes 'headcount, security welfare check conducted by CSO Fibbes 47 prisoners sighted all appear in good health'. Despite the check occurring on the day shift, it was essentially completed as a night time check. CSO Fibbes had a torch and was essentially trying to ascertain from prisoners who were sleeping whether there were any signs of life. CSO Fibbes indicated this was extremely difficult.

At 07:19 all cells were electronically unlocked so that any prisoner who wished to exit could do so by pushing a button inside their cell. CSO Fibbes did not see Mr McCarty up around this time.

The AGCC unlock and lockaway procedure required that floor officers were required to remain on the floor at all times. However, there was no procedure providing specific direction regarding the duty of the floor officer during the cell access period.

The CCTV footage of CSO Fibbes reveals that during this period, CSO Fibbes spent approximately 1 hour and 20 minutes at the officer's station, with approximately 36 of those minutes with her back to the unit. CSO Fibbes was of the view that she did not think there was a responsibility to walk around through the unit or to check on the prisoners in the cell. Acting Area Manager Lackey and General Manager Howden were of the expectation that during any period of unlock a CSO should be patrolling

and walking around the unit, including looking into prisoners' cells to ensure nothing untoward is occurring.

The medication trolley arrived shortly before 08:30 and medication was distributed by RN Brown. RN Brown says that she did not have Mr McCarty called down to receive his medication. She did not note that Mr McCarty had 'refused' to take his medication, because there was still the opportunity for him to receive his medication in the afternoon medication round and because he was not taking essential medications.

At 08:30, CSO Fibbes secured all the doors. This meant that all cell doors were locked regardless of whether a prisoner was in their cell or not. CSO Fibbes' general process was that if an inmate was asleep she would not disturb them as long as things appeared fine. If the inmate is awake in the cell, CSO Fibbes would ask the inmate if they were coming out. CSO Fibbes could not recall whether she engaged with Mr McCarty at the 08:30 lockaway. Most corrective staff indicated that if a prisoner was asleep they would not wake them however CSO's Lawson and Dwan indicated their personal practices were to wake prisoners who were asleep. The logbook records a welfare check at 08:30 and 09:40. There is no notation that all prisoners appear in good health. CSO Fibbes explained that this was because it was not a specific check of every single prisoner, but rather a check on those prisoners that could be observed in the common areas and yard within the unit.

At the time of Mr McCarty's death, there was no requirement for a CSO to confirm the apparent good health of a prisoner at 08:30.

CSO Fibbes cannot recall where Mr McCarty was during the morning headcount, the 07:15 unlock and 08:30 lockaway.

CSO Fibbes left the unit at 08:36 and did not return until 09:40 when she conducted a welfare check. At the time, there was no QCS procedure that required CSO's to do a welfare check between the 08:30 lockaway and the 11:00 muster.

The electronic cell lock records indicate that at no time between Mr McCarty's cell door going into access mode at 07:19 until all the doors were again electronically opened at 11:01 was the door opened. This indicates Mr McCarty did not exit his cell that morning and that no other prisoner entered Mr McCarty's cell. The video footage also confirms no person entered Mr McCarty's cell during the relevant period.

CSO Fibbes and McFarlane searched cells 20 and 21 at 11:06 and 11:09 respectively. No prohibited items were confiscated. Following this, CSO Fibbes then commenced locking shut all of the cell doors starting at cell 50. She got to cell 19 and observed Mr McCarty was under the covers of his bed. CSO Fibbes requested Mr McCarty to exit his cell. CSO Fibbes observed several spots of blood on the floor and Mr McCarty's face to be a strange yellow colour. She believed that Mr McCarty was possibly dead. CSO Fibbes called a Code Blue and sought assistance from fellow officers. She did not enter the cell any further because she was not wearing protective gloves and she was concerned for her safety given the number of prisoners who were in the common area near Mr McCarty's cell.

CSO's Lewis and McFarlane attended to provide assistance. CSO Lewis entered Mr McCarty's cell. CSO Fibbes and CSO McFarlane waited outside Mr McCarty's cell. CSO Lewis says that he entered the cell and tried to get Mr McCarty's attention by asking him if he was awake. CSO Lewis pulled back the doona and noticed that Mr McCarty's face was very yellow and there was a lot of blood over his chest and on

the bedding. CSO Lewis informed CSO Fibbes and CSO McFarlane that he did not think Mr McCarty was breathing. CSO Lewis exited the cell to wait for the nurses to arrive. CSO Lewis did not check Mr McCarty's pulse or commence CPR.

A number of nurses attended and confirmed Mr McCarty was deceased. RN Haimes noted that Mr McCarty was not cool to touch but noted he had been covered by a doona. A number of other CSO's attended the unit to provide assistance given the nature of the incident. They assisted by moving prisoners to the exercise yard.

Acting Area Manager Lackey attended and was provided with some preliminary information that indicated Mr McCarty had inflicted the injury to himself. He decided to move prisoners from the exercise yard to their cells because he wanted to restore individual control over each person rather than having them as a group in the exercise yard. The prisoners were behaving appropriately, however there was the potential for disharmony if prisoners were left in the exercise yard when lunch was due.

Acting Area Manager Lackey says that if there had been some concern about another prisoner being involved in the death of Mr McCarty he would have kept the inmates in the exercise yard to try and identify anyone who may have been involved, collect the clothing of the prisoners and hold them separately until the prisoners could be interviewed by police. Former General Manager Howden was of the view that only in exceptional circumstances should clothing not be retained from prisoners. There was no policy or procedure in place at the time of Mr McCarty's death that dealt with the issue of scene preservation.

QAS paramedics arrived at Mr McCarty's cell at 11:41. Advanced Care Paramedic Dickson noted Mr McCarty was unresponsive, pale to yellow in colour with slight rigor in neck and shoulder, cold to touch with fixed and dilated pupils.

QPS attendance

A number of police officers from the CSIU attended as well as a Forensic Scientist who processed the scene. No damage to the cell locking mechanism of Mr McCarty's cell was identified.

A search of Mr McCarty's cell located a razor blade in the sink with a number of blood droplets. At the base of the sink was an amount of blood, which had been covered by clothing and a number of droplets of blood on the floor between the sink and Mr McCarty's bed. Mr McCarty was wearing socks and had traces of blood on the bottom of his socks. Mr McCarty had a towel placed around his neck. A search of the cell also located a number of razor blades, upon inspection, these razors had been pulled apart.

It was concluded Mr McCarty's injury was self-inflicted.

All inmates of C5 were interviewed on 30 April 2011. These interviews were recorded on digital recorder. The audio recordings are of a poor quality, it was often difficult to hear the inmate talking and, in some of the interviews, the persons present for the interview were not identified.

There appears to have been no strategy adopted by the two separate interviewing teams about:

- how to undertake the interviews. For example, some inmates were warned about their right to remain silent and to obtain legal representation, other

inmates were not provided with any warning and some inmates were specifically advised they were not a suspect. For those inmates that were not warned, it is unclear whether they were aware that they were being recorded.
- what information to provide to the inmates about what had occurred. For example, some inmates were told the police were investigating what occurred today and asked what knowledge they had about this whereas other prisoners were specifically advised at the commencement of the interview that the police were investigating the death of a prisoner. Also, when inmates were notified of Mr McCarty's death, this notification was not done in a sensitive manner or alternatively, discussion about Mr McCarty's death was not done in a sensitive manner.
- about what information to seek from the inmates. For example, some witnesses were asked about Mr McCarty's routine whereas others were not.
- in one interview, where an inmate was warned, the inmate had to request that the interview be discontinued a number of times before interviewing officers finally desisted from questioning.

At the time of Mr McCarty's death, Detective Senior Constable Anderson had only been with CSIU for a number of weeks. He said he believed he and the other interviewing team discussed their initial conclusion that the death was self inflicted and so the other prisoners were being interviewed to identify witnesses and not suspects. There was no specific discussion about what information would be sought from the prisoners. He had no knowledge that the other interviewing team would be issuing warnings to prisoners and assumed that they would all be conducted in the manner he conducted the interviews which was to speak to the prisoners about any information they may have had.

Autopsy results

An autopsy examination was carried out on 2 May 2011 by an experienced forensic pathologist, Dr Nathan Milne.

He indicated the injury could have been inflicted from minutes to hours prior to Mr McCarty's death being discovered. He indicated it was a difficult determination to make, simply relying on the evidence of nurses and paramedics regarding the body temperature. Dr Milne was of the view he may have been able to have provided a more accurate assessment if he had attended the scene. He indicated that it was a rare occurrence to be called out to the scene of apparent suicides. Detective Senior Constable Anderson explained that the decision to call a pathologist to the scene was one that was made by the Regional Forensic Co-ordinator.

Dr Milne concluded that although the incised wound to Mr McCarty's neck was relatively small, it had damaged major blood vessels in the neck and was the cause of death. Both Dr Milne and Dr Griffin were of the view that for Mr McCarty to have made the injury in the way he did, which required sufficient control over his fine motor skills, would suggest that he was not intoxicated at the time of injury.

Dr Griffin and Dr Milne gave an estimated survival time after the wound had been inflicted of around five – 10 minutes. Dr Griffin was of the view that such an injury was difficult to survive even if Mr McCarty had been found immediately after injuring himself.

Dr Milne noted the injury was consistent with being self-inflicted.

Toxicology testing of the post mortem femoral vein blood showed Naproxen at a therapeutic concentration, Sertraline within the toxic range and Tramadol within the potentially fatal range.

Dr Milne concluded Mr McCarty's cause of death was:
1.(a) incised wound to neck
2. coronary atherosclerosis, emphysema, mixed drug toxicity

Although it is considered that the incised wound to the neck alone is significant enough to cause death, Dr Milne considered the presence of Mr McCarty's emphysema and coronary atherosclerosis would have made him more susceptible to the effects of blood loss, and may have hastened his death. Similarly, mixed drug toxicity may also have contributed to death by suppressing Mr McCarty's breathing.

At a later point, analysis was conducted on the post mortem vitreous humour sample.

Professor Brown, a Professor of Biomedical Science at the University of Southern Queensland, provided a report to AGCC's legal representatives commenting on the toxicology results. Professor Brown was of the opinion that Tramal and Sertraline were both subject to the effects of post-mortem redistribution and that the concentration at the time of death was very likely to be less than at the time the samples were taken but the proportional change could not be estimated, given the samples were taken at least 48 hours after death. Professor Brown was of the view that taking into account the effects of post-mortem redistribution, the levels of Tramadol and Sertraline could be consistent with the administration of these medications as prescribed. Dr Griffin was of the opinion that Sertraline undergoes variable post mortem redistribution. He believed that it was possible the results for Sertraline and Tramal may have been inflated due to the effects of exsanguination. Dr Griffin also noted from reviewing the material that there were no clear opportunities for Mr McCarty to overdose.

Dr Milne remained of the view that mixed drug toxicity played a role however he confirmed that Mr McCarty would have died from his neck wound irrespective of the coronary atherosclerosis, emphysema and mixed drug toxicity. Dr Milne was of the opinion that the toxicology results could be consistent either with the administration of the prescribed doses of the drugs in question or they could be an accurate reflection of ante mortem levels. Dr Milne agreed that at its highest, all he could say was that mixed drug toxicity may have contributed to Mr McCarty's death.

Investigation findings

Nothing from the forensic examination of Mr McCarty's cell was indicative of the involvement of another person in his death. There was no evidence of violence on examination of the cell or at autopsy other than the fatal wound.

Detective Senior Constable Anderson was satisfied there was no evidence of the involvement of another person in the death either by foul play or by rendering assistance to Mr McCarty.

Mr McCarty was locked down in his cell in the early evening of 29 April 2011 and there was no evidence indicating Mr McCarty was let out of his cell or that his cell was opened after lockdown.

As part of the investigation, Detective Senior Constable Anderson made contact with Mr McCarty's general practitioner, Dr Jones. Dr Jones stated that Mr McCarty had told him 'if I was to ever return to prison I would kill myself'.

Conclusions

I conclude that Mr McCarty inflicted the laceration to his neck without assistance from or the knowledge of, any other person. It is unknown why Mr McCarty took his own life.

There is very little evidence, even in hindsight, that points to a deterioration in mood in the weeks leading to his suicide, I am satisfied there is no basis on which staff at AGCC could have been expected to reasonably have been aware before the fact of Mr McCarty's actions of either 29 or 30 April 2011.

In light of all of the evidence, including the three opinions regarding the toxicology results, the statements of the doctors and nurses regarding the administration of medication, that there were no signs of Mr McCarty stockpiling his medication as would be expected and that Mr McCarty was able to inflict the injury in the manner that he did, I have disregarded mixed drug toxicity as a contributing factor to Mr McCarty's death.

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 the oral evidence given at the inquest and all of the material contained in the exhibits, I am able to make the following findings in relation to those matters:

Identity of the deceased – The deceased person was Lawrence McCarty.

How he died - Mr McCarty intentionally took his own life while in custody on remand at Arthur Gorrie Correctional Centre.

Place of death – He died at Wacol in Queensland.

Date of death – He died between 29 and 30 April 2011.

Cause of death – Mr McCarty died from exsanguination due to an incised wound to his neck

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.

The circumstances of this case have already been reviewed from that perspective by the inspectors appointed by the Chief Inspector.

In their report they made the following recommendations:

1. AGCC management ensure that written directions are issued to officers (in the form of a local procedure or post order) that clearly outlines the

responsibilities of officers whilst in the unit during periods of cell access and when undertaking welfare checks.

2. AGCC management institute a process (included in a local procedure or post order) that requires staff to be able to unequivocally determine the good health of a prisoner prior to locking them up in their cell at the 08:30 lock away (which should include waking sleeping prisoners to engage with them).

3. QCS review both the Prisoner Musters and Headcounts and Prisoner Unlock and Lock-away Procedures and make necessary amendments to clarify what is required of centres when unlocking prisoners.

4. QCS request that the Corrective Services Investigation Unit (CSIU) review this case and express some view as to what may have been the relative benefit of processing the prisoners in C5 in such a manner that would have allowed their examination/collection of evidence. Any advice from the CSIU should then be used to review, and if necessary, amend the current Preservation of Crime Scene Procedure.

5. AGCC management issue a direction to officers who control in-unit cameras (in the form of a local procedure or post order) that subject to operational requirements PTZ cameras should be left in a resting position that maximises the coverage of the unit.

AGCC and QCS provided responses in relation to these recommendations. All of the recommendations have been implemented. There is now a post order that requires CSO's to be satisfied of the apparent good health of the prisoner at unlock and 08:30 lockaway. The QCS unlock policy now requires that officers must ensure that an accurate head count and apparent good health check of prisoners is completed before an unlock commences, which ensures that each prisoner is responsive to direction. Officers must converse with those prisoners whose behaviour or non-responsiveness indicates he/she may not be in apparent good health. If the prisoner fails to respond to the direction, further steps must be taken to ensure the good care and well being of the prisoner. The same is required at lock away.

AGCC post orders now require CSO's to conduct at least two unit patrols between 08:30 and 11:00 when the cells are unlocked. A minimum of an hour between unit patrols must be maintained and the patrols include observations of every cell to ensure the apparent good health of those prisoners.

The Preservation of Crime Scene and Evidence procedure came into effect on 30 August 2011.

There remain only a few matters warranting further consideration from a prevention perspective. They are:

- How should reception staff respond if a prisoner discloses prior contact with mental health care providers?
- Should the distribution of disposable razors be further restricted?
- When should forensic pathologists attend a death scene?
- Is investigation planning within the CSIU adequate?

Response to disclosure of mental health care

The Health Management Plan undertaken when a prisoner enters a correctional centre requires the person undertaking the assessment to query whether the prisoner has previously received treatment by a psychiatrist or a psychologist. Whilst there is a section that allows comments to be made, there is no guidance given as to what further inquiries should be made if the prisoner answers in the affirmative.

Recommendation 1: Response to mental illness disclosures

Accordingly, I recommend that Queensland Health amend the health management plan and any associated form to encourage further information to be sought from a prisoner who discloses they have or are seeing a psychologist or psychiatrist.

Misuse of disposable razors

It seems the dismantling of razors by prisoners intent on using the blades for various purposes – including as weapons - is not uncommon. Senior officers at AGCC and QCS indicated various options to reduce the availability of the razors had been considered but none was without significant complication and disadvantage.

Counsel for QCS explained that providing disposable razors and toothbrushes to all prisoners in the mainstream population commenced in 2010 to assist in the prevention of the spread of communicable diseases. She stated that the risks of dismantling razors are small and that there are a number of other items that could also be used as weapons. Counsel for QCS also submitted that the dismantling of razors has been identified as a risk and steps are in place to manage this risk.

In the circumstances I do not consider I have sufficient evidence to take the matter further.

Death scene attendance by pathologists

The time of Mr McCarty's death could not be established with any precision. Although little turned on that in this case, in others it could be important. Reliable evidence relevant to the issue could have been obtained had a forensic pathologist attended the death scene soon after the death was reported. Indeed, it is likely that by attending the death scene such specialists could secure valuable evidence in many cases. The inquest was advised that such attendance is now rare, at least in South East Queensland.

Recommendation 2: Forensic pathologists at death scenes

In view of the valuable evidence forensic pathologists are likely to be able to gather at many death scenes, I recommend the Chief Forensic Pathologist liaise with an officer appointed by the Commissioner of the QPS to develop a protocol for determining which cases the on-call forensic pathologist will usually attend and mechanisms for facilitating this attendance.

CSIU investigation planning

The questioning of inmates housed in the same cell block as the deceased was haphazard and inconsistent. There was no investigation planning by the various officers undertaking those interviews. That had no impact on the outcome of this case but in others it could result in valuable evidence being lost or corrupted.

Recommendation 3: Review of CSIU investigation planning

I recommend that the Officer in Charge of the CSIU review the unit's procedures to ensure appropriate investigation planning is mandated in all cases.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
April 2013