CITATION: *Inquest into the death of Robert Martin Johnson* [2012] NTMC 005	
TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0014/2010
DELIVERED ON:	7 March 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	4 February 2011, 25 – 29 July 2011, 24 & 25 August 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, Suicide by Hanging, Care and Treatment of Deceased in Prison**

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Director of Correctional Services:	Mr Stephen Walsh SC
Family of the Deceased:	Dr Peggy Dwyer
Ms Tina Edwards:	Ms Helena Blundell
Mr Michael Collins, Mr Alan McGlinn, Mr Kieran O'Shaughnessy, and Mr James Shaw:	Ms Jodi Truman

Judgment category classification:	A
Judgement ID number:	[2012] NTMC 005
Number of paragraphs:	200
Number of pages:	46

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0014/2010

In the matter of an Inquest into the death of
ROBERT MARTIN JOHNSON
ON 23 JANUARY 2010
AT DARWIN

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Mr Robert Martin Johnson (the Deceased) was 34 years old when he died on 23 January 2010. The Deceased hanged himself whilst on remand at the Darwin Correctional Centre.

2. The Deceased's death was a "reportable death" as he was in custody when he died. An Inquest into his death was mandatory pursuant to section 15 of the *Coroners Act.*

3. On Saturday 23 January 2010 the Deceased was occupying a single person cell in C Block. At approximately 5.40 am prisoner officers conducted a cell check and noticed nothing unusual about the Deceased. However, on unlock at 7.40 am, the Deceased was found hanging from a shelf in his cell. A torn bed sheet had been fashioned into a noose. A Code Blue was called and resuscitation of the Deceased was attempted without success.

4. There was no evidence of any third party involvement in the death. I find the death was self-inflicted.

5. Although the cause of death is clear, pursuant to section 26(1) of the *Coroners Act*, I am also required to investigate and report on the care, supervision and treatment of the Deceased while in custody and any matters

that caused or contributed to his death. Important issues surrounding the death, and relevant to the care and treatment of the Deceased while in custody, were explored in this Inquest. In particular I had cause to consider whether

5.1 the reception, screening, and assessment of prisoners was adequate as to their mental health or "at risk" status,

5.2 the Deceased had been allegedly assaulted by prison officers on 15 November 2009, and if so, whether that incident was connected to his death,

5.3 the safety of the cell layout, and

5.4 operational defibrillators were adequately available.

6. I was assisted by all parties to this Inquest. The Executive Director of Correctional Services was proactive in his approach to this Inquest and many of his staff demonstrated a willingness to improve services. Submissions filed on behalf of Correctional Services were particularly helpful. They demonstrated that Correctional Services identified relevant issues arising from this death and actively responded to them.

7. The family and partner of the Deceased also actively contributed to this Inquest. In particular, I was assisted by the detailed and thoughtful evidence provided by the Deceased's sister, Ms Sharon Wallace, an experienced Aboriginal Health Worker.

8. During the Inquest I heard evidence about an incident that occurred between prison officers and the Deceased on 15 November 2009 (the November incident). Although the evidence was somewhat contradictory, I heard evidence from several prisoners that the Deceased was assaulted by prison officers in circumstances where the level of force used appeared to be excessive in the circumstances. I saw CCTV footage which showed prison

officers dragging the apparently unconscious Deceased to a segregation cell. I saw photos of his injured feet. I heard evidence that the Deceased was later found vomiting and apparently fitting in the segregation cell. I saw CCTV footage of the Deceased in an apparently semi unconscious state being wheeled from the segregation cell to the medical unit following a Code Blue.

9. In contrast to the above, I received statements and reports from the prison officers involved, in which they denied the allegations and asserted that minimum force was used as required in the circumstances of the Deceased's non-compliance with directions. I also received medical evidence which did not appear consistent with the severity of the alleged assault.

10. Pursuant to section 35(3) of the *Coroners Act* I considered whether the November incident might be connected to the death. It is possible that the November incident might have provided a contextual or background stressor experienced by the Deceased which might have been one of a number of factors in his decision to take his own life. However, I found no direct evidence of a connection between the November incident and the death.

11. I received into evidence a detailed and extensive brief of investigation prepared by Detective Senior Constable David Allan. I also received and considered recommendations prepared by Detective Senior Sergeant Scott Pollock. I heard evidence from Police Officers D/S/C David Allan and S/C Tim Sandry; Prison Officers, SPO Alicia Aberdeen-White, SPO Alan Ludwig, PO Shane Russell, PO David Viktus, PO Anthony Voss, PO John Thomas, PO Paul Beams, PO Colin Schofield, PO Darren Purtell, PO Jeffrey Dawson, PO Andrew Irwin, Chief Prison Officer Mark Nayda, the Executive Director of Northern Territory Correctional Services, Kenneth Middlebrook; Doctors Judith Finlay, and David Mathison; Registered Nurse Danielle Pinner; Paramedic Antony Kwiatowski; inmates Mr Warren Wesley, Mr John Kurrungaiyi, Mr Geoffery Wanambi, Mr David Dixon

Japaltjarri, Mr James Kostanjevic, and Mr Jason Tyson; Aboriginal Health Worker and sister of the Deceased, Ms Sharon Wallace; partner of the Deceased, Ms Tina Edwards. Prison Officers James Shaw, Alan McGlinn, and Michael Collins were called to give evidence but declined to answer relevant questions.

12. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

13. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

14. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have

been committed in connection with a death or disaster investigated by the coroner."

Background

Background – Personal Circumstances

15. The Deceased was born on 18 May 1975 in Cunnamulla, Queensland to Ms Ellen Mary Ebsworth and Mr Robert Martin Green Snr. The Deceased's parents separated following his birth and he grew up in the care of his mother and her new partner Mr Glenn Johnson. The Deceased was adopted by Mr Glenn Johnson at about the age of 13. The Deceased is survived by his mother and adopted father and his eleven brothers and sisters. He is survived by his partner, Ms Tina Edwards, and seven children. He is deeply missed by his family, his children and his friends.

16. As a child, the Deceased's family moved regularly due to his step-father's work as a truck driver. The family moved to Melbourne when the Deceased was about five years old, but he also lived in Maryborough, Charleville, Oakey and Toowoomba. The Deceased struggled with attending new schools and left school when about 14. He had more success with sports, excelling at athletics, boxing and rugby. The Deceased was brought up with strong Christian values and beliefs and maintained his religious beliefs until his death.

17. At about the age of 15 the Deceased met his biological father for the first time. Thereafter, the Deceased maintained regular contact with his father until his father's death in 2000. He continued to have contact with his father's side of the family until his own death.

18. The Deceased's childhood was not entirely happy. He experienced incidents of violence, of self-harm, and, as a teenager, drug addiction. He came into conflict with the law and was incarcerated and made a ward of the state. His drug and alcohol addictions continued to mar his life and contribute to his

adult offending. When he died he had a lengthy and serious criminal history spanning the Northern Territory, Queensland and New South Wales.

19. When not in prison, the Deceased raised his children, made concerted efforts at drug rehabilitation, and gained employment. The Deceased obtained work on properties where his talent as a horseman was valued, or in construction. The Deceased was also a talented artist and skilled musician.

Background - Mental Health Issues 2003-2005

20. In 2003 the Deceased was admitted to a psychiatric hospital in Logan, Queensland, having suffered a break down.

21. On 26 July 2004, police found the Deceased apparently threatening self-harm and they took him to the Katherine District Hospital. The Deceased was discharged into the care of family members.

22. On 2 September 2004 the Deceased was briefly placed "at risk" at the Darwin Correctional Centre by a visiting medical officer, due to his history of suicide attempts, but his "at risk" status was removed the same day when he was assessed by Forensic Mental Health Services.

23. On 8 September 2004 the Deceased was transported from the Darwin Correctional Centre to the Katherine Court. He suffered a panic attack and self-harmed *en route* by bashing his head. He was placed "at risk" by a prison nurse, but was taken off later that day when seen by Forensic Mental Health Services.

24. On 22 September 2004 the Deceased was taken to the Katherine District Hospital by ambulance after consuming an overdose of Diazepam tablets.

25. On 16 March 2005 the Deceased was arrested in Katherine for stealing and assault. He attempted to hang himself whilst being held in the police cells. Information recorded on the Police Custody Computer System (IJIS) details

that at 14.22 hours the Deceased was carried from the shower by another prisoner. Responding police members found a thin green piece of clothing tied around the Deceased's neck which was cut away. The Deceased was taken to the Katherine District Hospital and was admitted as an involuntary patient into Cowdy Ward.

26. A Court ordered psychological assessment dated March 2005 reported that the Deceased was not suffering from any major mental illness but had previously suffered from reactive depression. He was diagnosed as having significant anger issues and a borderline personality disorder.

27. On 5 May 2005 the Deceased self-presented at the Katherine District Hospital complaining of suicidal ideation. He was medivaced to Cowdy Ward and admitted as a voluntary patient.

28. Following Court appearances the Deceased was placed "at risk" for short periods on 14 and 16 May 2005.

29. The Deceased's mental health records reveal that he saw Mental Health practitioners twenty two times between July 2004 and June 2005. The consultations addressed the Deceased's mental health issues, his treatment plans and medications. All the Deceased's medical files contain alerts or warnings about his history of suicidal ideation, depression and poly-substance abuse.

30. Notwithstanding the above, there are no documented instances of any further self-harm or suicide attempts between May 2005 and his death, a period of four and a half years.

Issue 1

Whether the reception, screening, and assessment of prisoners was adequate as to their mental health or "at risk" status

31. The Deceased was received into the Darwin Correctional Centre (the prison) on 10 October 2009 having been charged with drug, assault and robbery

offences. He was granted bail on 15 October 2009 and released. On 29 October 2009 the Deceased breached his bail by assaulting a family member with a woomera. In response to the family violence, the Deceased's children were taken into care by Family and Community Services. The Deceased believed his children would be returned to their mother if he handed himself into police. He turned himself in and was received back into the prison on 29 October 2009. However, his children remained in care, and court proceedings for their return were initiated by Ms Edwards.

Reception – First Stage

32. On both 10 and 29 October 2009, PO Viktus conducted the Deceased's reception into the prion which included an initial "at risk" assessment. PO Viktus asked the Deceased specified questions and entered his answers on an "Immediate Risk / Needs Assessment" (IRNA) form. The completed IRNA form was faxed through to the medical centre for consideration by medical staff during the Deceased's medical assessment (Reception - Second Stage).

33. The IRNA form contained a section entitled "Individual Risk Factors – Suicide/Self-Harm" which required nine questions to be addressed in order to assess whether a prisoner was "at risk" of self-harm or suicide. Some of the questions required answers from the Deceased, others relied on the observations of the prison officer, or relied on information from other sources (e.g. from the arresting or transport officers).

34. The IRNA forms concerning the Deceased's two admissions in October 2009 record that the Deceased gave different responses to the question "Has the offender ever attempted to kill him or herself?". On 10 October 2009, PO Viktus recorded the Deceased as answering "Yes" to this question, with the comment "Has had episodes in the past 10 years ago"; however, on 29 October 2009, the Deceased answered "No" to the same question.

35. This discrepancy or error was possible because prison officers did not, and were not required, to check answers given by prisoners against answers

given on previous admissions. Further, admitting officers did not routinely check, and were not required to check, behavioural alerts on a prisoner's electronic records. According to PO Viktus, prison officers in reception simply relied on prisoners giving them true and accurate answers.

36. As at October 2009, behavioural alerts about the Deceased's previous attempts at self-harm (in 2004 and 2005) were on the Integrated Justice Information System (IJIS). However, the alerts were not on the Integrated Offender Management System (IOMS), which had only recently been introduced at the prison (less than two months earlier). I heard evidence from Mr Kenneth Middlebrook the Executive Director, NTCS, and accept that the IOMS system was still in a transitional stage and further implementations and improvements were planned to take place to address this discrepency.

37. Although PO Viktus did not access the electronic information, he was aware, at least on 10 October 2009, that the Deceased had a prior history of attempted suicide within the previous ten years. This information would certainly have been reinforced if the electronic alerts were accessed and would not have been missed on the second intake, if the electronic history was referred to.

38. However, I accept that knowledge of this past (non-recent) history had to be balanced against the Deceased's presentation on reception. On the evidence available I am satisfied that on neither occasion did the Deceased give PO Viktus any indication that he needed to be placed "at risk".

39. Furthermore, there was no evidence to suggest that the assessment by PO Viktus on either occasion was wrong, or that his assessment should or would have changed if the behavioural alerts had been accessed.

Reception – Second Stage

40. The second stage of the process involved a physical and mental health examination of the Deceased, including an assessment of his "at risk" status, by medical personnel at the Prison Medical Centre. The prison procedures require that medical assessments occur within 24 hours after reception into custody. If a prisoner is seen by a registered nurse (the usual practice), or if a risk is identified, a medical practitioner is required to assess and examine the prisoner within 72 hours of reception (or at such earlier time as requested by the nurse).

41. The Deceased was seen by a registered nurse and a medical practitioner following each admission in October 2009. On 10 October 2009, he was seen by registered nurse, Amber Revell, and by Dr Judith Findlay. On 30 October 2009 (and within 24 hours of admission), the Deceased was assessed by registered nurse, Chris Davis, and by Dr David Mathison.

42. The assessments of RN Revell and RN Davis are recorded on the Deceased's Patient Reception Form. The records show that each nurse took base line medical observations and asked the Deceased questions to determine whether; he had any immediate medical needs or, anything might indicate he was "at risk". The Patient Reception Form included questions about how the Deceased was feeling, whether he was depressed, or wanted to hurt himself, or had tried to kill or hurt himself in the past. On each occasion the Deceased is recorded as answering "No" to these questions. However, on 10 October 2009, RN Revell noted, next to the question, "Have you tried to kill or hurt yourself in the past", "No. according to previous notes has history??". The note suggests to me that RN Revell must have accessed records and was aware that the Deceased may have attempted self-harm or suicide in the past.

43. A self-assessment measure, known as a "Happy Face Score", was also used by each nurse. This involved showing a picture of five different faces and asking the Deceased to choose the face which best matched his feelings.

The Patient Reception Forms record the Deceased as having nominated Happy Face 2 on 10 October and 1 on 30 October 2009.

44. Following the nurse assessments, the Deceased saw Dr Judith Findlay on 10 October and Dr David Mathison on 30 October.

45. Both doctors gave evidence in the Inquest but neither had any independent recollection of seeing the Deceased on those dates. In their statements and oral evidence they each described the general procedure they followed in assessing prisoners following reception. This included:

45.1 Developing a rapport by asking general questions, such as how he was feeling, eating and sleeping, and whether he had any concerns about being in custody, issues or problems,

45.2 Checking the medical history, including the Patient Reception Form,

45.3 Conducting a general medical examination and assessment of physical and acute mental health on admission,

45.4 Making observations about general appearance and demeanour, as to, for example, mood, level of consciousness and orientation, and whether there were any signs of psychosis or other unusual behaviour,

45.5 Asking about state of mind, whether he wished to hurt himself or anyone else at that time, and

45.6 Recording the observations and any relevant notes on the Patient Reception Form.

46. Dr Findlay and Dr Mathison each recorded the Deceased's general appearance and demeanour as "Pleasant alert and co-operative". Both said that they would not have selected this particular description if they held concerns about his mental state.

47. Both Dr Findlay and Dr Mathison emphasised that the assessment of a prisoner's mental health, for the purposes of determining their "at risk" status, is a contemporaneous exercise, requiring consideration of the prisoner's present state of mind and demeanour. Whilst background information, such as a past history of self-harming behaviour, can be relevant to the determination, it is less significant where the history dates back a number of years and the contemporaneous history and presentation does not otherwise indicate that the person is at risk. In the Deceased's case, his last recorded incidents of self-harm occurred over four years prior to his admissions into custody in October 2009.

48. On the basis of the procedure described by the doctors and the results of their assessments neither Dr Findlay nor Dr Mathison had any concerns about the Deceased's state of mind when they assessed him. Accordingly, there was no necessity or any appropriate basis for either of them to place the Deceased "at risk".

49. Again, I heard no evidence that suggested that the assessments made by the doctors on the relevant dates were other than correct.

Reception – NTCS Response

50. As at October 2009, there was a heavy reliance on self-reporting by prisoners of matters that might place them "at risk". I accept the submissions of Counsel for the Deceased's family, that there was a real and genuine risk that prisoner's might misreport such matters. Reasons that were discussed in these proceedings included a desire to avoid being placed in "at risk" cells, which are bare and isolating, and a lack of cross cultural sensitivity or understanding.

51. Persons responsible for making "at risk" assessments ought to consider all available and relevant information. This would always include a person's current presentation. However, a person's history would almost always be another relevant consideration. The weight to be given to a history would no

doubt depend in part on its age and in part on what it contains. In particular, behavioural alerts, a history of self-harm or suicide attempts, or other history of depression or mental illness must be considered relevant to an "at risk" assessment.

52. Prison procedures should ensure that relevant information, as known to the authorities, is considered. To this end, I heard evidence and received affidavits from Mr Kenneth Middlebrook, and Mr Mark Nayda, the Chief Prison Officer, about the changes that had been made to reception and "at risk" assessments since this death.

53. I am informed that prison officers on reception have been directed to undertake the following additional steps when assessing a prisoner during the reception process:

53.1 Check the IJIS system for any relevant alerts concerning a prisoner being admitted into custody;

53.2 Enter the details of any relevant IJIS alerts found onto the IOMS system in the Offender Details screen under the warning tab; and

53.3 Forward the IJIS QNAME and the details of any relevant alerts for the prisoner, via facsimile, to the Prison Medical Centre.

54. I am told this direction will remain in force until the computer database systems are upgraded to enable the automated sharing of on–line alerts between IOMS and IJIS.

55. In addition, I received evidence that a third tier of "at risk" assessment has been added to the intake procedure in the Darwin Correctional Centre (only). A Senior Assessment Officer with specific training in suicide awareness is required to assess prisoners the morning after their reception. The process involves a one-on-one meeting with the prisoner. The officer is required to consider the prisoner's history (including any previous episodes

of self-harm), information provided by the prisoner via the IRNA form, and any further information provided by the prisoner at that meeting.

November 2009 – January 2010: Ongoing Assessment of "At Risk" Status

56. I heard evidence that the process of identifying "at risk" prisoners is not limited to the reception but is subject to ongoing review.

57. Documentary records and statements from a number of people who had contact with the Deceased prior to his death were received into evidence and provided some insight into the Deceased's state of mind.

The Deceased's Partner, Ms Tina Edwards

58. I heard evidence from Ms Tina Edwards, the Deceased's partner. She normally visited the Deceased twice weekly and spoke to him by telephone, however, at the time of his death she had not seen him for a month. Orders made on 17 December 2009 under the Care and Protection of Children Act (NT), prohibited the Deceased from having any direct contact with his children and Ms Edwards and prevented her visiting the Deceased. This upset the Deceased and Ms Edwards told me that "It was hurting him a lot because I couldn't actually go in to see him" and "(he) wanted to have contact with his kids".

59. Ms Edward's last contact with the Deceased was by telephone on the day before his death (Friday 22 January 2010). The Deceased made five telephone calls to Ms Edwards during the day which were recorded. I listened to those calls during the Inquest. I will briefly, and in point form, summarise relevant parts from each call:

    59.1 In call 160 at 09:02 hours: The Deceased talked to Ms Edwards about pleading guilty and being sentenced to four years imprisonment; he said, "I just give up" and "I don't feel like living anymore"; he was upset at not seeing his children; Ms Edwards provided reasons for not doing anything

"stupid", and reminded him that he wanted to teach the children things in the future.

59.2 In call 161 at 10:27 hours: The Deceased said he felt depressed; the plea of guilty was discussed; Ms Edwards said that she and the children would wait for the Deceased.

59.3 In call 162 at 11:41 hours: They discussed the welfare of the children; and the Deceased spoke briefly to his daughter, Zara, he told her he loved and missed her; they agreed to ring later.

59.4 Call 163 at 14:24 hours: was disconnected without any conversation.

59.5 In call 164 at 14:34 hours: They discussed the children's schooling; the Deceased said he was not alright; he was upset and not talking to anyone except Ms Edwards; he said he loved his family; he said they would talk tomorrow if he can.

60. The last call took place approximately 12 minutes before the Deceased was secured in his cell for the night.

61. Although prison phone calls are recorded, they are only selectively listened to by prison officers. There was no evidence to suggest that any prison officer listened to any of these calls when they were made, so no-one at the prison was aware of the content of these calls at that time.

62. In her evidence Ms Edwards told me that in the past she had raised concerns with NT Police and with prison officers about the Deceased's mental state, including in October 2009. But she did not raise any concerns following these calls. In her statement Ms Edwards said that she "felt comfortable" that "he was alright", "he was still holding up emotionally". She stated "I felt comfortable knowing that he'll be okay, because it was almost lock down, that he will be okay until I speak to him tomorrow", "he didn't come

across to be that depressed". The Deceased's suicide was not anticipated by Ms Edwards, it was a complete shock to her.

Other Prisoners

63. I also received a statement and heard evidence from Mr Geoffrey Wanambi, who was on remand in 'C' Block, and who occupied the cell next to the Deceased. Upon reception, the Deceased had nominated Mr Wanambi as a person known to him, and the evidence shows that he was someone the Deceased talked to.

64. I heard evidence that the Deceased discussed his problems with Mr Wanambi, including arguments he was having with his wife, his worries about his children, and his concern for his mother who had cancer.

65. It was disturbing to hear that the Deceased told Mr Wanambi that he was going to kill himself. Mr Wanambi told me he felt worried for the Deceased but that he did not tell anyone about his concerns. Mr Wanambi said he did not use the intercom to tell anyone "because it was the middle of the night", nor did he tell any of the officers during the night checks. This was explained by Mr Wanambi in his statement, when he said: "I think he was talking joke but he was real".

66. Another inmate, Mr Pearce Kelly, described noticing a change in the Deceased's behaviour in the week prior to his death, from being "pretty cheerful", "pretty normal" and "talkative", to "a lot quieter" the last few days. On the afternoon before his death Mr Kelly overheard the Deceased speaking to someone on the telephone. He heard the Deceased say he loved and missed the person. Mr Kelly thought the Deceased sounded "a little bit upset", because he was missing his family. Mr Kelly also heard someone "sobbing" during the night of the death but he didn't know who it was or where it came from. Mr Kelly did not inform anyone of his observations.

67. Mr David Robertson played cards and snooker with the Deceased. He thought the Deceased was "having a bit of a hard time … with court" and "something was bothering him". He recalled seeing the Deceased on the last afternoon, with an "expression on his face". But Mr Robertson didn't think the Deceased was going to kill himself.

68. Indeed, I received statements from other prisoners, and although their observations of the Deceased varied, no prisoner raised any concern about the Deceased with prison officers.

The Deceased's Lawyer, Ms Balagengadaran

69. I received a statement from Ms Chantelle Balagengadaran, the Deceased's lawyer. Ms Balagengadaran saw him during the period 12 October 2009 to 21 January 2010, including: on one or two occasions between October 2009 and mid-December 2009, for a Court hearing on 21 December 2009; and on four occasions in the week prior to his death (i.e. on 16, 18, 20 and 21 January 2010), either at the Prison or at Court.

70. In her statement Ms Balagengadaran described the Deceased's demeanour as "normal", "even jovial". She said that he was "always able to give … really clear coherent instructions" and "was quite savvy" about the criminal system. On the four occasions she saw him in the week prior to his death she said "he was laughing about a few matters", "was happy with the progression of the committal" and "was calm … not anxious about having two matters in court". On the last occasion she saw him, two days prior to his death, Ms Balagengadaran said he had just entered pleas in respect of two offences on one of his files, the sentencing for which had been adjourned to 1 February 2010. She did not advise him about sentence other than to tell him she would be in contact with him prior to his sentencing date.

71. Ms Balagengadaran knew how to make "at risk" notifications to the Court or the prison if a prisoner made disclosures of self-harm. She had made

notifications in the past for other clients. However, during the three + months that she acted for the Deceased she was not aware of any threats of self-harm nor had she noticed anything that suggested he should be placed "at risk". Ms Balagengadaran reported that she was "really surprised" when she heard about his death.

Prison Officers

72. A/SPO Colin Schofield, was the senior prison officer based in 'C' Block from mid-November 2009 up to, and including, the date of the Deceased's death. A/SPO Schofield provided a statement and gave evidence. He last saw the Deceased the day before his death (22 January 2010) at lock down, at around 14:50-15:00 hours. He recalled the Deceased's demeanour as "the same as usual". A/SPO Schofield said he saw nothing which indicated that the Deceased was or might be "at risk" and nor was he alerted anything by any prisoner during the period he was based in 'C' Block.

73. PO Byron Vivian also provided a statement and gave evidence. He was aware that the Deceased was having "some problems with family matters with his children". However, he said the Deceased "seemed pretty normal" when he inspected of the Deceased's cell on 18 January 2010.

Medical Personnel

74. Dr David Mathison had two dealings with the Deceased in the days leading up to his death. The first was a consultation with the Deceased at the Prison Medical Centre on 15 January 2010, just over a week before his death. The purpose of the appointment was to advise the Deceased of the details of an ultra-sound report. Based on the absence of any additional comments made by him in his notes of this consultation, Dr Mathison presumed it was uneventful. On the second occasion, Dr Mathison was walking past the Deceased who was with a group of prisoners. Dr Mathison noticed that the Deceased was behaving in a somewhat aggressive or upset manner. Dr Mathison said he did not pay much attention, nor did he stop to engage the

Deceased in conversation, as it was not uncommon to see prisoners "acting out" in that way.

75. The Deceased had two "court return" medical assessments at the Darwin Correctional Centre in the week prior to his death conducted in accordance with the standard court return procedures. The first assessment was made by RN Melissa Scrivener on 19 January 2010 and the second was made by RN Amber Revell on 21 January 2010, two days before his death. Both nurses noted that there were "No issues at court return" and recorded the Deceased as describing his own state of mind as "HF1" (i.e. the happiest face) on the "Happy Face Score".

"At Risk" – NTSC Response

76. As outlined in the Affidavit of Mr Middlebrook dated 24 June 2011 and his evidence, a review of the "At Risk" Manual has been undertaken by the Department of Justice (through NTCS), in conjunction with the Department of Health, International SOS and FMHS, amongst others. The intention of the review was to ensure that all staff had access to a clear and easy to understand document that set out their obligations and the procedures to be followed when a prisoner is considered to be "at risk".

77. Mr Middlebrook informs me that as a result of this review, a number of key improvements are being, or will be, made to the procedures for the assessment, placement and protection of prisoners who are "at risk" of self-harm or suicide, such as:

77.2 The consistent and comprehensive use of the IOMS system across the whole of NTCS,

77.3 The extension of access to view and enter data on IOMS, to enable the sharing of information relevant to the care and protection of "at risk" prisoners by relevant personnel across these agencies; and

77.4 The creation of an "At Risk" team consisting of personnel from NTCS, FMHS, the Alcohol and Other Drug Prison in Reach Program (Department of Health) and Aged and Disability Services to better manage the care of "At Risk" prisoners.

"At Risk" - Conclusion

78. This Inquest disclosed information that, if known by the prison authorities, should have raised concerns about the Deceased's possible intention to self-harm. In particular, I refer to the phone calls made on his last day and his stated intention to kill himself. Tragically, these signals were misinterpreted or missed and they were not made known to the prison authorities.

79. It is equally clear on the evidence, that the Deceased did not disclose his deeply felt concerns and likely depression to any prison officer or medical practitioner, although he had opportunities to do so. Indeed it is obvious that he did not take the happy face test seriously, when it was shown to him on his court returns during the days before his death.

80. Whilst the "at risk" assessments in place appeared thorough, they clearly failed the Deceased and his family. I accept that no process will be watertight. Those determined to commit suicide will continue to successfully hide their intentions from others and find a means to do so. But I am persuaded by the evidence of Ms Sharon Wallace, the Deceased's sister and Aboriginal Health Worker, that there remains room for institutional improvement, over and above that identified by NTCS, particularly as to cross cultural issues.

81. In his evidence Mr Middlebrook referred to the 2007 report by Richard Harding, Michael Levy and John Podmore, "Review of Primary Health Care, Mental Health, Disability and Related Services for prisoners and Juvenile Detainees in the Northern Territory". The Report notes that the overwhelming percentage of prisoners in the Northern Territory is

Aboriginal, and although the statistics are now dated the fact remains unchanged. In very brief summary, the Report relevantly identified that:

81.1 Aboriginal health service providers are barely involved at all in detainee health care, and the contract with International SOS did not require that the provider employ Aboriginal health workers,

81.2 A "smiley face" test as an identifier of "at risk" status is ludicrous and there is no validated effectiveness for this test. The Reporters discovered that prisoners alerted each other to what face they should identify in order to avoid segregation and medical or custodial attention. The Report concluded that "This test should be discontinued and International SOS in conjunction with the Forensic Mental health Unit, should develop a simple mental health screening test.", and

81.3 Custodial staff were not engaged with health issues and saw their role as solely that of custodian. There was no managerial oversight to ensure that the health and well-being of prisoners was a key part of the role of officers.

82. Ms Wallace highlighted the lack of Aboriginal Liaison Officers and health workers in the prison system. As to Aboriginal Liaison Officers, Mr Middlebrook readily acknowledged that he would like to see one attached to every major accommodation block. Perhaps the Deceased might have confided in such a person or perhaps Mr Wanambi might have told such a person of his concerns about the Deceased.

83. Ms Wallace also recommended prison officers be trained in Mental Health First Aid. I heard evidence from numerous prison officers who expressed a desire for further training in this area. Such courses, including courses specifically tailored to Indigenous and cross cultural issues, are readily available. I would add that prison medical staff should also receive this training.

84. It is obvious that the "happy/smiley face" test, as a risk assessment tool, is at best irrelevant and at worst misleading. A cross culturally appropriate test should be urgently implemented.

85. Ultimately, whilst there is room for improvement in the assessment of "at risk" prisoners, there was nothing reported by the Deceased, reported about the Deceased, or obvious from behaviour known to prison personnel, that ought to have alerted them to his intentions.

Issue 2

The November Incident – whether there was an assault and whether the incident contributed to the death

86. On 15 November 2009, an incident occurred in which the Deceased alleged he was assaulted by three prison officers during an attempt to remove him from his cell and place him in segregation.

87. I permitted evidence to be lead about this incident because I considered that it might have been a stressor or factor playing on the Deceased's mind when he decided to take his own life; and section 26(1)(a) of the *Coroners Act*, relevantly requires that I "investigate and report on the care, supervision and treatment" of the Deceased whilst he was being held in custody. Accordingly, I heard evidence about the incident on 15 November 2009 in order to determine whether it contributed in any way to the Deceased's death on 23 January 2010.

Deceased's Account of the Incident

88. The Deceased's account of the incident is set out in handwritten notes dated 15 November 2009 and in a Statutory Declaration dated 18 November 2009.

89. The Deceased said that at around 08:30 hours on the morning of Sunday 15 November 2009 he was assaulted in his cell by two prison officers. He identified one from his name plaque as "M. Collins", a senior officer. The assault occurred when the officers attempted to take him "down the back" to

solitary confinement after he exited his cell early during the morning unlock. The Deceased said when he was grabbed by the officers he sat down and held onto the toilet. He was then kneed, kicked and punched to the back of the head, his face and back. One of the officers then put an arm around his neck and started to choke and lift him until he passed out. The Deceased said he awoke in another cell but passed out again only to find himself in the Prison Medical Centre vomiting under an oxygen mask, and then in hospital in a neck brace and getting x-rays.

Prison Officers' Accounts of the Incident

90. The officers involved in this incident were identified as SPO Michael Collins and POs Allan McGlinn and James Shaw. Their version of the incident is given in IOMS Officer's Reports dated 15 November 2009 and in their records of interview dated 1 and 8 December 2009. They were each called to give evidence at the Inquest but each declined to answer questions about the incident on the basis that their answers might tend to incriminate them.

91. In a nutshell, the officers involved claimed that the Deceased kicked his meal tray and left his cell early in the morning against procedure and was slow to respond and "aggressive" when asked to return to his cell. The Deceased became "aggressive" and verbally abusive towards the officers when they visited him in his cell a short time later when he was told he would be put into solitary confinement.

92. Exactly what the Deceased did that was referred to as "aggressive" is not disclosed in the prison officers IOMs reports which were written on the day of the incident. As to what occurred immediately before the "use of force" PO Collins said in his IOMs report "The Prisoner refused to leave the cell and minimum force had to be used" and in his interview he said "he came at and started struggling. He went back and grabbed the bowl" and "He then came at us but that is my opinion". PO McGlinn said in his IOMs report

"The Prisoner refused to leave the cell and minimum force had to be used" and in his interview he said "he just flat out refused and it went from there into a struggle" and "I'm not sure how he came at the officers or how it came about, but as I turned around, that is when the struggle was on".

93. SPO Collins admitted placing the Deceased in a "head lock" or "head hold" in order to "control him" so he "couldn't spit or bite". The officers claim the Deceased refused to walk and so was carried to the confinement cell. All of the officers refuted the allegations made by the Deceased that he was punched and kicked to the torso, kneed, kicked and punched in the head.

94. The officers claim that they left the Deceased in Cell 28 sitting on the floor. They denied he was unconscious.

95. When the Deceased was next checked (at approximately 09:30 or 09:32), he was observed by these officers to be lying on the floor of the cell, shaking, breathing erratically and with vomit beside him. A Code Blue was called by SPO Michael Collins and the Deceased was attended by medical personnel.

96. PO Kieran O'Shaughnessy was not directly involved in the incident. He had assisted with the morning unlock procedure in 'C' Block and was present with SPO Collins and POs Shaw and McGlinn when they asked the Deceased to return to his cell because he had moved out of it too early. He was not present for much of the incident as he was directed by SPO Collins to retrieve a bed roll, and then some handcuffs. When he reached the cell the first time with the bedroll, he saw the other three officers surrounding the toilet behind the privacy screen but was unable to see the Deceased. When he returned to the cell the second time, he saw the Deceased lying on his stomach in the middle of the cell with SPO Collins kneeling down restraining his head and POs McGlinn and Shaw each holding one of the Deceased's arms behind his back. He described the Deceased as "appearing compliant" and could hear him "moaning and groaning". PO O'Shaughnessy said PO Shaw placed the handcuffs on the Deceased and, with PO McGlinn,

lifted the Deceased by his arms and started to escort him out of the block. The Deceased "refused to walk", so he picked up his legs and they carried him to the separate confinement cell. He said he did not see any injuries on the Deceased and that he "appeared conscious".

97. PO O'Shaughnessy was present when they returned to the Deceased's confinement cell 28 and saw the Deceased lying on the floor, face down, legs towards the door. He was directed by SPO Collins to call a Code Blue Medical emergency.

Witnesses to the Incident - Prisoners in 'C' Block

98. A number of prisoners in 'C' Block gave accounts of the incident they witnessed on 15 November 2009.

99. Mr Janez Kostanjevec said he saw the entire incident and provided a statement. He said he was standing about four - five metres from the cell and saw SPO Collins and PO McGlinn rush and grab the Deceased in his cell, push him to the ground near his toilet and that SPO Collins then started kicking him. He saw PO McGlinn drop his knee on the Deceased's head. He saw PO McGlinn put the Deceased into a headlock and choke him until he got knocked out. He did not see PO Shaw kick or punch the Deceased at any time. Mr Kostanjevec saw the officers drag the Deceased from his cell and then pick him up and carry him. Mr Kostanjevec thought the Deceased appeared unconscious.

100. In his oral evidence, Mr Kostanjevec elaborated on his statement, and under detailed cross–examination by Counsel representing the prison officers involved in the incident, appeared to exaggerate details of his version of the assault. Furthermore, the CCTV footage that I saw of the yard area demonstrated that Mr Kostanjevec might not have had as good a view of the incident as he recalled.

101. Mr Kostanjevec gave evidence that very shortly after the incident he phoned Prison Intelligence to make a complaint about the incident. However, Mr Paul Beames, the Officer in Charge of the Intelligence Unit at the Prison, said that he was not aware of the incident until the following day when he was monitoring Mr Kostanjevec's calls and overheard him talking about it.

102. Mr Kostanjevec was frank about his dislike of SPO Collins. He said he does not like him because he is "demeaning" and "always growling" at prisoners.

103. Mr Greg Bading said he was about one and a half - two metres away and directly in front of the Deceased's cell when he saw SPO Collins kick the Deceased with his right foot while he was on the ground and PO McGlinn drop his knee from a height down onto the Deceased's. He saw one of the officers (he thinks it was PO McGlinn) put the Deceased in a neck hold and knock him out. Mr Bading said PO Shaw was watching from outside and only went into the cell when SPO Collins asked for help. PO Shaw then grabbed the Deceased by the leg and moved him into the middle of the cell. He saw the officers drag the Deceased out of the cell and he was unconscious.

104. Mr Lance Barclay and Mr Cameron Zele gave similar versions.

105. Mr Jason Tyson said he was standing across from the Deceased's cell and watched prison officers grab the Deceased with sheets, wrap him with the sheets and headlock him, "so he couldn't breathe" and "suffocated him". He says one of the officers strangled the Deceased with the sheets "till he went to sleep" and they "moved him out (of) that cell without bashing him up". He was unable to remember which prison officers were involved in this incident. His account is inconsistent with all the other evidence and is clearly unreliable.

106. Mr Geoffrey Wanambi said he was standing in the basketball court in the 'C' Block yard when he saw the Deceased punch SPO Michael Collins and

then SPO Collins punched him back. Mr Wanambi said the Deceased was "not listening" (to the officers) "because he felt sorry about his family problem". Mr Wanambi saw SPO Collins doing the "kicking and grabbing" and there were other officers in the cell but he did not know their names. He said SPO Collins kicked the Deceased "heaps". He saw the Deceased being dragged by his feet in his cell because he was unconscious. The officers grabbed him by the arms/shoulders and dragged him out of his cell.

107. Mr Warren Wesley said he was sitting with the Deceased in the yard near the basketball ring after the morning unlock when three officers walked past and told the Deceased to clean his cell. He said the Deceased didn't want to go to his cell and argued with the officers a bit, but afterwards finally walked to his cell. Mr Wesley said the three officers went into the Deceased's cell and "they were still arguing" but the young officer came out and told everyone to move away from the cell. The young officer stood near the door of the cell and the other officers were inside the cell with the Deceased. He said he heard swearing from the Deceased and the officers and the argument was about the Deceased not obeying the rules.

108. Mr Wesley then heard "a thud like someone hitting the floor". He could see straight into the Deceased's cell and he saw the Deceased's legs coming from behind the toilet barrier, with the two officers standing near his legs. After that, he saw the officers drag the Deceased from behind the toilet barrier into the cell near the bench, where they picked him up and put each of his arms over their shoulders and dragged him out of his cell. He said the Deceased was not moving and his feet were dragging behind him.

Medical Evidence - Treatment on 15 November 2009

109. Medical personnel at the Darwin Correctional Centre responded to the Code Blue. Upon their arrival at Cell 28, medical personnel found the Deceased to have a "pulse rapid and strong, vomiting and seizure activity mild present". He was taken by wheelchair to the Prison Medical Centre and given

midazolam 5mg which settled the Deceased. The Deceased told medical personnel that his neck and shoulder were sore.

110. He was transported by ambulance to the Royal Darwin Hospital Emergency Department. His Glasgow Coma Score was measured at 15, which is the highest level of alertness. He remained at that level of consciousness throughout his admission at the Royal Darwin Hospital Emergency Department.

111. The Deceased was seen by Dr David Denman at approximately 10:55 hours. The Deceased complained of neck pain, including pain all down his cervical spine, and right arm / muscular right shoulder pain, however, no evidence of any significant injury was identified and the Deceased was able to demonstrate full head control and full range of shoulder movement.

112. Medical investigations (including an x-ray of his cervical spine and clinical examination) revealed no signs of bony injury, nor any evidence of ligament injury. The doctor found that there was no loss of consciousness or concussion and no sign of head injury. The Deceased was treated with "Simple analgesia".

113. Dr Denman concluded that the Deceased was more likely to have had a "psuedoseizure" and the injury was not likely to result in "any significant or long standing damage/disability or reduced living style". He stated that he had "no concerns about discharging Mr Johnson back to the care of the prison staff". The Deceased was discharged from Royal Darwin Hospital at 14:17 hours and returned to the Darwin Correctional Centre.

114. I heard evidence that a "psuedoseizure" is a non-epileptic seizure or attack disorder which can be brought on by a number of things, such as extreme stress or a medical condition.

Medical Evidence - Treatment after 15 November 2009

115. The Deceased was referred back to the Emergency Department of Royal Darwin Hospital two days later (on 17 November 2009) by Dr Mathison, after complaining of "incapacitating pain" on the right side of his cervical spine, including intense pain when he moved his head or right arm, and an altered sensation at the base of his right thumb.

116. The Emergency Department doctor diagnosed a muscle spasm and informed the Deceased that the pain would lessen with time and to move his arm within limits of his pain.

117. Thereafter, the Prison Patient Appointment List records a number of appointments the Deceased had with medical personnel both in and outside the Prison (including the Royal Darwin Hospital, Palmerston Health Centre and Darwin Private Hospital), for ongoing pain management and further tests on his right shoulder up to 12 January 2010.

118. An x-ray of the Deceased's right shoulder taken on 1 December 2009 showed that there was "no fracture or dislocation visible, particularly involving the scapula".

119. An ultrasound on the Deceased's right shoulder on 12 January 2010 revealed a "tiny intrasubstance tear" (1.8mm in size), "mild tendinopathy" but with "no convincing tear" of the supraspinatus tendon, "slightly thickened" subacromial bursa, with "minimal" bursitis, and "minor bursal dragging beneath the CA ligament but (with) reasonable range of motion".

120. In his evidence, Dr Mathison agreed that "in an ideal world" the Deceased should have been referred for follow-up counselling after the incident on 15 November 2009.

Medical Request Forms - Pain Relief Medication Requested by Deceased

121. An issue was raised by Counsel for the Deceased's family during the hearing concerning the response of prison medical personnel to the medical request forms submitted by the Deceased after the incident on 15 November 2009.

122. The Deceased's prison medical records indicate that in November and December 2009, he submitted 5 Medical Request Forms in which he complained about the pain he was experiencing.

123. Notations made by nursing staff on those forms indicate that the forms were responded to and, in most instances, appointments were made for the Deceased to see a doctor at the Prison Medical Centre within a few days of the requests being made.

124. The "Patient PRN Medications List" records the Deceased as last being administered pain relief (i.e. analgesic) and anti-inflammatory medication on 9 December 2009.

125. In the last Medical Request Form, dated 23 December 2009, the Deceased said he was "still experiencing pain" in the area of his right shoulder "and it hasn't gone back to normal". As noted above an ultrasound was booked for 12 January.

126. I heard evidence that nursing staff make twice daily rounds at the Darwin Correctional Centre, and prisoners are able to request pain relief medication. Pain relief would therefore have been available to the Deceased if he had needed and requested it from the nurses.

Action taken by NTCS following Allegation of Assault

127. When the NTCS Intelligence Officer Paul Beames became aware of the incident on 16 November 2009, the matter was referred to the NT Police for investigation because it involved a possible crime.

128. The three prison officers involved in the incident were excluded from working in 'C' Block and instructed to avoid contact with the Deceased at the Darwin Correctional Centre, pending the outcome of the NT Police investigation into the incident (and any subsequent criminal proceedings).

129. Whilst Darwin Correctional Centre staff rosters prepared prior to 15 November 2009 indicate that POs McGlinn and Shaw were scheduled to work in 'C' Block after the incident, there was no reliable evidence that the officers in fact worked in 'C' Block from the time the above direction was made and up until the date of the Deceased's death. In his oral evidence, Mr Middlebrook conceded that it may have been possible for the officers to have worked in an area where they did not expect to have direct contact with the Deceased, including in the visiting area of the prison.

Did the November 2009 Incident contribute to the Death?

130. From 16 November 2009 onwards the Deceased had a number of telephone conversations with Ms Edwards, and one conversation with his sister, Ms Sharon Wallace, in which the incident on 15 November 2009 was discussed. These calls related to the medical treatment the Deceased received, complaints made by him to NT Police, the Ombudsman and his lawyer, the injuries and ongoing pain he experienced after the incident, the prison officers involved and compensation for the incident.

131. On 9 January 2010, in a telephone conversation with Ms Edwards, the Deceased told her that he believed everything was "going good" and he was no longer getting "hassled" by prison officers.

132. The last mention made by the Deceased of the November incident was the day before his death, however, this was in the context of him discussing with Ms Edwards the use he was planning to make of the alleged assault in his upcoming sentencing.

133. Mr Geoffrey Wanambi told me that the Deceased did not talk to him about being worried about the officers after the incident on 15 November 2009. As far as Mr Wanambi knew, the main issues worrying the Deceased's were his partner and the care of their children.

134. There were avenues available for the Deceased to make a formal complaint about the November incident, and the Deceased did complain to the Ombudsman, his lawyer, and the Health and Community Services Complaints Commission.

135. It was suggested by Counsel for the family and the Deceased's partner that prison officers should have picked up on what they described as a change in the Deceased's demeanour and behaviour on 15 November 2009, namely, his failure to comply with procedures when normally he was a compliant prisoner. Further, that this change in behaviour, coupled with the Deceased's prior history of self-harm, should have prompted prison officers to refer the Deceased to a welfare officer or Aboriginal Liaison Officer (or even Forensic Mental Health Services) to discuss any concerns or problems that may have been on his mind.

136. Prison officers should have access to behavioural alerts. If they had concerns about a prisoner they should access and consider those alerts as part of the information they take into account in determining whether a prisoner might be "at risk". However, there is no evidence that the prison officers were aware or could be aware of the Deceased's medical background. Indeed, Prisoners are entitled to a measure of privacy and there are confidentiality issues surrounding the disclosure of a prisoner's medical history to prison officers.

137. I note that the Deceased did not himself **at any time** request to see a welfare officer, Aboriginal Liaison Officer, counsellor or mental health professional or otherwise seek help for any mental health issue. In particular, in not one

of the 5 Medical Request Forms submitted by the Deceased in November and December 2009 did he request such help.

138. Counsel for the Deceased's family questioned the appropriateness of the Deceased being placed in a single cell. However, I heard evidence that generally prisoners prefer single cells. The Deceased never complained about his cell. Further, as previously noted, the Deceased was housed next to someone he knew, Mr Wanambi.

139. There was no hint from any of the medical professionals who treated the Deceased for his injuries following the incident that he was an "at risk" person.

140. The Deceased was before the Court and was seen by his lawyer two days before his death and there was no hint that he was "at risk".

141. It is possible that the November incident might have provided a contextual or background stressor experienced by the Deceased which might have been one of a number of factors in his decision to take his own life. However, I found no direct evidence of a connection between the November incident and the death. In my view, any suggested connection is speculative.

Was the Deceased assaulted?

142. It is clear from the prison officers' accounts that there was a use of force. There are conflicting accounts as to the nature and extent of force used and the circumstances in which it was applied.

143. I heard evidence from several prisoners that the Deceased was assaulted by prison officers in circumstances where the level of force used appeared to be excessive in the circumstances. I saw CCTV footage which showed prison officers dragging an apparently unconscious Deceased to a segregation cell. I saw photos of his injured feet. I heard evidence that the Deceased was later found vomiting and apparently fitting in the segregation cell. I saw CCTV footage of the Deceased in an apparently semi unconscious state being

wheeled from the segregation cell to the medical unit following a Code Blue.

144. In contrast to the above, I received statements and reports from the prison officers involved, in which they denied the allegations and asserted that minimum force was used as required in the circumstances of the Deceased's non-compliance with directions. I also received medical evidence which did not appear consistent with the severity of the alleged assault.

145. Section 35(3) of the *Coroners Act* requires me to report to the Commissioner of Police and the Director of Public Prosecutions if I believe that a crime may have been committed **in connection** with a death. I am of the opinion that a crime of unlawful assault on the deceased may well have been committed on 15 November 2009. However as I could find no evidence of **a connection** between the incident and the death, I cannot make any such report pursuant to section 35.

Use of Force/Separate Confinement

146. NTCS Directive No. 2.4.2, "Separate Confinement and the Non Entitlement to Prescribed Privileges" permits the separate confinement of prisoners in circumstances of: prison misconduct, administrative separation, medical separation and protective separation. Administrative separation may be used where an officer **reasonably** believes separate confinement of a prisoner is necessary to maintain the security and good order of the prisoner or prison.

147. Darwin Correctional Centre's standard operating procedure 9.12 sets out the reporting procedures to be followed after a use of force or separate confinement. The procedure makes it clear that separate confinement may not be used for punishment for prisoner misbehaviour except as a prison misconduct proceedings penalty.

148. NTCS Directive 2.2.4 deals with the use of force. The stated purpose of the Directive is to ensure that force only be used when deemed absolutely

necessary and that the degree of force used should be the minimum necessary. The Directive requires prison officers to first attempt to diffuse a situation by talking to the prisoner in the presence of other officers. If a "cell extraction" is required to remove the prisoner from a cell, a video recording must be made. The exception being when an incident of violence is not anticipated and requires an immediate response. In his oral evidence, Mr Middlebrook said he would expect a video camera to be used to record a cell extraction if it was anticipated by prison officers that there would be a problem in moving a prisoner from their cell. He expected that a video camera would be retrieved in circumstances where a prison officer had been sent away to get handcuffs because of an incident that had arisen.

149. Where an incident has not been video recorded, NTCS Directive 2.2.4 requires that photographs must be taken of all prisoners involved, regardless of whether they have sustained visible injuries. Photographs of officers with visible injuries must also be taken to assist with any possible criminal or disciplinary action and for accident/incident recording purposes. Mr Middlebrook told me he would have expected photographs to be taken of the Deceased after the incident in accordance with this requirement.

150. The incident was not videoed and no photos were taken of the Deceased or any officer.

Was there a breach of the NTSC directives?

151. In his interview, SPO Collins described the Deceased's early leaving of his cell as a "small discipline procedure". The Deceased was then reluctant or tardy in response to directions to return to his cell but ultimately compliant. It appears that without further inquiry as to the Deceased's usual behaviour or history, SPO Collins decided to separately confine the Deceased. It is not readily apparent to me that there were **reasonable** grounds for SPO Collins to believe that separate confinement of the Deceased was necessary to maintain the security and good order of the prisoner or prison. Indeed, it

seems possible that SPO Collins was using separate confinement as a punishment for a minor disciplinary infraction in contradiction to the internal directive.

152. When the direction for separate confinement was communicated to the Deceased he verbally protested and refused to accompany the prison officers. At that point, SPO Collins and PO McGlinn must have anticipated the need to use force. The application of force could have been briefly delayed. The officers could have stepped out of the cell and a video recorder could have been retrieved. If force was still required to obtain compliance, the cell extraction could have been videoed. Alternatively, the video could have been retrieved at the same time as the handcuffs. It appears to me that there was no genuine attempt to comply with the internal directive to video this anticipated use of force.

153. After the use of force, photographs of the Deceased should have been taken. No excuse was given for the failure to comply with this requirement.

154. Had any or all of these directions been followed, it is possible the incident and the uncertainty surrounding the incident might have been avoided.

155. Whilst there was perhaps no direct evidence on the issue, I certainly got the impression that the video and photo directives were not commonly followed. The evidence of the prison officers suggested that video recorders and cameras were not readily available or routinely used.

156. I note that the directives requiring videos and photographs are in the best interest of both prisoners and prison officers. They provide protection for prisoners against abuse of powers and protection for prison officers against false complaints. They deserve to be reinforced in training and followed in practice.

157. Counsel for the family requested I make a recommendation concerning the further investigation of this incident by Correctional Services in order to

determine whether there were breaches of the directives or the Code of Conduct by any officer. I shall make that recommendation.

Issue 3

Cell Safety

158. The NT Police investigation found that the Deceased used a torn bed sheet looped behind a shelf in his cell and wrapped around his neck to hang himself. The shelf was located near the door in the Deceased's cell. A bolt holding one side of the shelf in place was missing, enabling the shelf to be lifted up to create a gap for the sheet to be looped behind it.

159. There was no evidence that pointed to when the bolt was removed. It was not found in his cell during the crime scene examination, so it was not removed after lockdown. It must have been removed at some earlier point in time.

18 January 2010 - Last Cell Inspection and Maintenance/Serviceability Check of Cell 12

160. The last recorded cell inspection and maintenance/serviceability check of Cell 12 was conducted by POs Shane Russell and Byran Vivian on 18 January 2010.

161. Neither officer could specifically recall checking the shelf, nor noticing whether the bolt was in place or missing on that date. However, both said they would have inspected the cell in accordance with their training and procedures, which included a rear to front, top to bottom search of the cell looking, amongst other things, for any defects or damaged items in the cell. Following their inspection, Cell 12 was deemed to be safe and fit for occupation.

162. Photographs taken by NT Police after the Deceased's death show that the shelf was still affixed to the wall and was not obviously missing a bolt. Visual inspection of the shelf alone would not have identified that there was

a missing bolt. But PO Russell said he usually liked to run his hand along the top of the shelf, take any items off it, and "give the shelf a bit of a shake" to make sure it wasn't loose.

163. The NT Police investigation concluded, and I accept, that sometime between the last cell inspection on 18 January 2010 and 22 January 2010, the bolt was removed and disposed of.

23 January 2010 - Last Body Count and Security Check of Cell 12

164. Three body count and security checks were conducted in 'C' Block during the night shift before the Deceased was discovered hanging in his cell. The prison officers who were rostered on that shift included Acting CPO Elisha Aberdeen-White and POs Anthony Vos, William Firth and Nicklaus Robison.

165. The procedures for conducting body count and security checks of prisoners during the evening and nightshifts require that officers conduct a minimum of three full body counts per evening and night shift, at intervals not exceeding two to three hours. Officers must be satisfied the prisoner is breathing.

166. The last check of 'C' Block was conducted by PO Vos at approximately 05:30 to 05:50 hours on 23 January 2010. PO Vos said he conducted this check in accordance with procedure and did not notice anything unusual or out of the ordinary. Given the close proximity of the shelf to the door of Cell 12, it is clear that PO Vos would have seen the Deceased, if had been hanging at that time.

167. CCTV footage between the last cell check and when the Deceased was found shows that no person entered the cell.

168. The investigating officer from NT Police found that the Deceased hung himself sometime after the final check of 'C' Block at around 05:40 hours

(and prior to his discovery at approximately 07:40 hours) on 23 January 2010. I agree.

Recommendations and NTCS Response

169. The NT Police made two recommendations as to the way in which cell searches are conducted, namely, that NTCS takes steps to:

169.1 Refine and improve current cell search methodologies by implementing a specific and systematic cell searching procedure to identify cell deficiencies and/or hazards; and

169.2 Improve the recording of cell searches through the introduction of a standardised cell check form i.e. detailed checklists for cell searches, specifically highlighting the serviceability of commonly held items such as bookshelves, desks, beds etc.

170. No recommendations were made by NT Police in relation to the way in which body counts and security checks were conducted.

171. Detective Senior Sergeant Scott Pollock of the Major Crime Section, in considering the NT Police recommendations on this issue, commented that "'(h)anging points' are notoriously difficult to prevent in all circumstances" and "(a) thorough inspection may have delayed the death of Johnson but not necessarily prevented it from occurring".

172. I was informed that the procedures for undertaking cell searches at the Prison do not prescribe a standard or systematic methodology because each cell search is necessarily different. The number of prisoners and items belonging to each prisoner in a cell, for example, will vary the way a cell search is conducted. Officers are trained to identify and report any features of a cell which may pose a risk to the health or safety of a prisoner, including, any potential hanging points.

173. Mr Middlebrook told me that, in his long standing experience, cell search checklists are not a realistic option and result in less effective and comprehensive searches. In his view, the most effective cell searches are conducted by prison officers who follow a routine where they check the fixtures and security features of a cell and take notice of any changes, such as, for example, the movement of property between cells and any other day to day differences. Mr Middlebrook also commented that it is not the purpose of a cell search to pull the cell apart by ripping out or turning over all private property of a prisoner.

174. I am informed that the following measures have been taken by NTCS since the Deceased's death:

174.1 A risk assessment of the shelving in 'C' Block has been conducted and shelving identical to the shelf used by the Deceased has been removed; and

174.2 The reporting of any possible hanging points detected during cell searches has been reinforced as part of the ongoing training of prison officers at the Prison.

175. Counsel for the family and partner of the Deceased requested a recommendation concerning the widespread use of non-rip sheets. These heavy sheets are used in "at risk" cells. I heard evidence as to the impracticality of non-rip sheets being used across the general prison population, and I decline to make that recommendation.

Cell Safety - Conclusion

176. I agree with the observations of Detective Senior Sergeant Scott Pollock of NT Police, that it is very difficult (even impossible) to prevent all hanging points in a cell in every conceivable circumstance.

177. In his oral evidence Mr Middlebrook noted that the availability of potential hanging points in cells at the Darwin Correctional Centre is exacerbated by

the inappropriate and out-dated design and age of the prison. It is understandably near impossible to remove all potential hanging points in this older facility.

178. I am advised that a new prison is being built to replace the Darwin Correctional Centre and which will adopt Victorian Fire and Safety guidelines and incorporate a new safer cell design. It is anticipated that the new prison will be handed over to the Territory in 2014.

179. I appreciate that there is a difficulty balancing cell amenity and comfort as against complete sterility which might provide the "safest" setting. Commissioner Elliott Johnston QC, in the National Report of the Royal Commission into Aboriginal Deaths in Custody, 1991, stated:

> "It appears to be generally accepted that no cell can be made totally safe without the removal of all fittings. Plainly, sensible precautions to remove obvious anchor points are essential. However, the physical means employed to limit the opportunity for suicide may ultimately result in a physical environment which is so oppressive that suicide attempts are in fact more likely.
>
> …
>
> Thus, striking a balance between minimising the opportunity for a prisoner to cause harm to himself and exacerbating the stress and isolation which a person may experience in custody requires a considerable degree of thought".

180. I am satisfied that the cell searches were conducted thoroughly and in accordance with appropriate procedures. I am also satisfied that the NTCS response in conducting a cell risk assessment was appropriate. I make no further recommendations as to cell safety.

Issue 4

Availability of Operational Defibrillators

181. An issue arose in respect of the defibrillator that was fetched to resuscitate the Deceased after he was discovered hanging in his cell on 23 January 2010.

182. The first defibrillator machine which was retrieved from the Prison Medical Centre was missing the pads and cables required to attach the machine to the Deceased. There were no signs or labels on or near the machine to indicate that it was not complete.

183. RN Pinner told me that the pads and cables for this defibrillator had been removed and placed on a separate trolley so that it was ready for use in the Prison Medical Centre. It appears that the prison officers who retrieved the defibrillator were unaware of this practice and had taken the defibrillator from the Prison Medical Centre because it was the closest located to Cell 12.

184. A second, complete defibrillation machine was immediately obtained from the Prison Administration Superintendent's Office and attached to the Deceased. No shock was administered as the machine gave audio advice not to shock the Deceased.

185. The evidence of all involved in the resuscitation attempts was that, at no time after the Deceased was discovered hanging in his cell, was there any sign of recovery or life. POs Schofield and Dawson each checked for a pulse on the Deceased but were unable to find one shortly after their arrival in Cell 12. RN Pinner said the Deceased was not breathing and was completely unresponsive when she arrived and there was no change in his condition at any time whilst CPR was being administered on him in the cell.

186. CPR efforts continued and oxygen was administered to the Deceased by prison officers and RN Pinner and, later, by ambulance paramedics.

187. One of the responding paramedics Mr Antoni Kwiatkowski gave evidence that there were no delays in reaching the Deceased (all access points at the prison being quickly opened) and that RN Pinner, and the prison officers administering CPR on the Deceased were doing a good job when the ambulance arrived. He said the Deceased had no pulse, was unconscious and not breathing upon his arrival and no signs of life were detected when paramedics took over the resuscitation efforts.

Response by NTCS and the Department of Health

188. No recommendations were made by NT Police in respect of this issue. However, I am advised that steps have been taken to improve the availability of defibrillators.

189. According to the affidavit of Ms Leila Collins dated 20 June 2011, as at 23 January 2010, there were four defibrillators at the prison. In March and April 2011, an additional 10 Zoll AEDs were installed across the correctional centres and juvenile detention centres in the Northern Territory, including six in Darwin and four in Alice Springs, at locations determined in consultation between officers of NTCS, the Department of Justice and the Department of Health. It is intended that the locations chosen for the additional AEDs will enable NTCS and medical personnel in those facilities to have faster and readier access to this equipment in the event of future medical emergencies.

190. Ms Collins further advised that the following measures are to be implemented:

190.1 All Prison Medical Centre Zoll E Series Defibrillators have been clearly identified and labelled as only for use by medical personnel and not to be removed from the Prison Medical Centre;

190.2 All Zoll AEDs have been wall mounted and will be clearly identified by their respective locations and labelled as transportable units;

190.3 Regular training in the use of Zoll AEDs by medical and non-medical personnel has commenced at the Darwin and Alice Springs Correctional Centres, including the juvenile facilities (and will supplement existing advanced life support training undertaken by medical personnel and senior first aid training undertaken by NTCS personnel); and

190.4 Annual simulations of emergency incidents and appropriate response involving both medical and NTCS personnel would commence at the Darwin and Alice Springs Correctional Centres (including the juvenile facilities) in the second half of 2011.

Conclusion - Defibrillator

191. There was no evidence that the delay in obtaining a complete defibrillator contributed to the death of the Deceased.

192. The steps taken by NTCS in response to the issue are appropriate. I make no further recommendations concerning this issue.

The Autopsy

193. An autopsy of the Deceased was conducted by Dr Terence Sinton, Director of Forensic pathology Unit, Royal Darwin Hospital, on 28 January 2010.

194. Dr Sinton found the cause of death to be hanging with no autopsy evidence of the involvement of any third person.

195. I accept those findings and find the cause of death to be hanging.

Recommendations

196. That Northern Territory Correctional Services increase the percentage of Aboriginal Liaison Officers and health workers in the prison system per head of prisoner population, with consideration being given to there being one Aboriginal Liaison Officer position for every major accommodation block.

197. That prison officers and medical personnel receive Mental Health First Aid training (or equivalent) with annual maintenance training.

198. That the "happy/smiley face" test, as an "at risk" assessment tool, be replaced with a cross culturally appropriate and validated assessment tool.

199. That the Northern Territory Correctional Services further investigate the incident that occurred between prison officers and the Deceased on 15 November 2009 in order to determine whether there were breaches of the directives or the Code of Conduct by any officer, and conduct any disciplinary proceedings as considered necessary.

Formal Findings

200. Pursuant to section 34 of the *Coroner's Act* ("the Act"), I find, as a result of evidence adduced at the public inquest, as follows:

(i) The Deceased person was Robert Martin Johnson born 18 May 1975 at Cunnamulla, Queensland. The Deceased lived in the Northern Territory of Australia.

(ii) The time and place of death was 8.41 am on 23 January 2010 at Royal Darwin Hospital.

(iii) The cause of death was asphyxiation by hanging.

(iv) Particulars required to register the death:

1. The Deceased was a male person of Australian Aboriginal origin.

2. The Deceased was unemployed.

3. The death was reported to the coroner at 9.00am on 23 January 2010 by Dr Stephen Asha, Emergency Department Consultant, Royal Darwin Hospital.

4. The cause of death was confirmed by post mortem examination carried out by Dr Sinton, Director, Forensic Pathology Unit, Royal Darwin Hospital and reported to the Coroner on 28 January 2010.

5. The Deceased's biological parents are Mrs Ellen Johnson and Mr Robert Martin Green. The Deceased was adopted by Mr Glen Edward Johnson when the Deceased was 13 years old.

Dated this Wednesday 7th day of March 2012.

_____

GREG CAVANAGH
TERRITORY CORONER