CITATION: *Inquest into the death of Bird* [2011] NTMC 050

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0018/2011
DELIVERED ON:	25 November
DELIVERED AT:	Darwin
HEARING DATE(s):	21 and 22 November 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in custody, death by self inflicted hanging, care and treatment whilst in custody.**

REPRESENTATION:

Counsel Assisting:	Dr Peggy Dwyer
Department of Health and Corrections:	Mr Tim Barrett

Judgment category classification:	A
Judgement ID number:	[2011] NTMC 050
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0018/2011

In the matter of an Inquest into the death of

BIRD
ON 20 January 2011
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Mr Paul Wayne Clarke, who formally changed his name to Bird, died at around 1.20pm on 20 January 2011 at Royal Darwin Hospital, at the age of 46. The cause of his death was acute hypoxic brain damage, which resulted from Bird tying a piece of sheet around his neck and hanging himself on 19 January 2011.

2. At the time of his death, Bird was an inmate on remand at Darwin Correction Centre.

3. Pursuant to section 34(1) of the *Coroners Act*, I must make findings in relation to:

   (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; and

   (v) any relevant circumstances concerning the death.

4. Section 34(2) of the Act operates to extend my functions 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".

5. For reasons which will appear below, this death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was a death of a person who immediately before his death was a "person held in custody". Person held in custody is defined under s.12 of the Act to include a person detained in prison. In addition, as a result of being a person held in custody immediately prior to his death, this inquest is mandatory pursuant to s.15(1) of the Act.

6. Since the deceased died while he was in custody, an inquest into his death is mandatory. Furthermore, section 26(1) of the *Coroner's Act* imposes an obligation on me to "investigate and report on the care, supervision and treatment of the person while being held in custody". I must also make such recommendations with respect to the prevention of future deaths in similar circumstances as I consider to be relevant (s.26(2)).

7. A broader recommendations power is set out in section 35(2), which provides that:

> "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".

8. I have had the benefit of a very thorough investigation brief which was prepared by Det. Brendan Hooper-Duffy, and supplemented by his colleague, Det. Senior Constable Julie Frost, who succeeded him as officer in charge. I am grateful to them both for their diligence and I am particularly appreciative of the sensitive and careful way in which Det. Frost responded to the needs of witnesses during the inquest.

9. During the inquest, I heard evidence from Prison Officers Jacob Bonson, Matthew James and John Keirs and from prisoner Esau Hodgson. I also heard evidence from Dr Mathison, the Medical Officer at Berrimah Correction Centre, Mr Elliot Becker, a psychologist and Mr Kenneth Middlebrook, the Executive Director of the Northern Territory Correctional Services (NTCS). The deceased's prison medical and management records were available to me during the inquest and Counsel Assisting tendered specific documents from his medical and Corrections file that were deemed to be most relevant.

10. I also received into evidence a number of statements from the deceased's best friend, Gail Moody, who was loyal to him until the end of his life, in spite of being shocked and distressed by the crime he committed. She was able to share with me that the deceased had made a valuable contribution to the community at different stages of his life – volunteering with the SES and rural fire service, helping in a charity to redistribute food to the needy and behaving as a loyal and caring friend to her and others. He suffered a lot in his life, and in turn, when he seemed to spiral out of control after his accident in 2007, he inflicted suffering on others that is deeply regrettable. His death is a sombre reminder of the loneliness and pain that many in our community experience.

11. After reading and hearing all the evidence I am satisfied that the deceased had complex physical and emotional needs and that significant efforts were made by staff at Darwin Correction Centre to provide him with an appropriate level of care.

12. While custodial and medical staff were aware that that the deceased's behaviour was at times very challenging, there was nothing to alert them to the fact that he would self harm on 19 January 2011 and there can be no criticism of any individual for failing to take appropriate steps to prevent his death.

The circumstances that brought him into custody

13. On 12 October 2007, the deceased sustained a serious injury whilst working as a security officer at the Beachfront Hotel, Nightcliff. He was escorting a patron out of the premises when a scuffle broke out and he ended up in hospital with a leg severely broken in two places. There were complications with his recovery and from that moment forward his life began to spiral downwards.

14. As a result of the injury, Bird began receiving weekly medical payments from Territory Insurance Office ("TIO") pursuant to a workers compensation claim. In early 2009, he became involved in a dispute with TIO regarding the calculation of his weekly payment. In October 2009, the Work Health Court found in favour of TIO, but the dispute relating to his entitlements, and his subsequent hardship, seemed to consume the deceased and he was deeply frustrated and angered by his predicament.

15. On 3 February 2010, the deceased committed an offence which shocked the Darwin community. He pushed a shopping trolley containing fireworks and a number of 20 litre jerry cans into the TIO office located at 47 Cavenagh Street, before rolling the trolley over and throwing a match onto it, causing it to ignite. Six staff members and three customers were in the vicinity of the trolley and many were serious injured. The deceased left the scene and immediately attended on Darwin police station, where he was arrested and charged with nine counts of attempted murder and one of arson. He admitted the factual matters set out above.

Reception into the prison system

16. The deceased arrived at Berrimah Correction Centre on 8 February 2010, and in accordance with the standard procedure, he saw a nurse and then a medical officer, to determine what medical issues he might have.

17. Nurse Simon Stafford did preliminary checks and filled out the appropriate documentation before handing the deceased on to Dr David Mathison. Dr Mathison noted that the deceased needed treatment for several minor issues such as conjunctivitis and varicose veins, and more significantly, that he had been diagnosed with HIV and would require regular medications. Arrangements were made with staff from Clinic 34 who had treated the deceased in the community to attend the Correction Centre and continue to treat him while he was in custody. Medications were supplied through the pharmacy of the Royal Darwin Hospital.

18. On the day of his arrival in prison, the deceased was seen by a psychiatrist, Ms Donna Schakelaar, from the Forensic Mental Health Team. Dr Schakelaar concluded that the deceased had "no overt psychosis or depression" and "no overt evidence of mania". She noted that he had "marked underlying anger" especially in relation to TIO and that she could not exclude post traumatic stress disorder.

Bird's mental health issues in custody

19. Bird went to court on numerous occasions during the 11 months he spent in custody and his behaviour was often destructive and disruptive.

20. On 13 August 2010, Kelly J ordered a psychiatric report in relation to the deceased's fitness to stand trial and his mental status at the time of bombing.

21. Dr Kevin Smith provided a report dated 4 October 2010 stating that the deceased was not mentally impaired at time of offence. This was supplemented by a further report on 17 January 2011, which indicated that he was not mentally ill or suffering from any mental condition, but was presently unfit to stand trial because he could not control his emotional behaviour. The next scheduled court date was 31 January 2011.

22. While in custody, the deceased displayed behaviour that made staff concerned for his mental health.

23. On 10 March 2010, he took a cord from his shirt, fashioned a noose and hung it through a faulty ceiling vent in his cell. He then sat down and read a book until he was discovered by guards. Bird was placed "at risk" on that day, but was taken off risk on 11 March when he was reviewed by Dr Schakelaar. He told her that he had no intention of harming himself that day or the day before, but he had wanted to "upset the officers". A note taken by Dr Schakelaar reads:

> "He was adament today that he had no intention to harm himself yesterday and has no intention to harm himself in the future. He felt that he was just pointing out the incompetence in the prison system re disintegrated grill at least a couple of years old, said that it was insane for an at risk prisoner to be placed in a cell that they could easily hang themselves". … Nil evidence of formal thought disorder, nil perceptual disturbances of any type. Nil delusional content expressed or evident today. Nil paranoid ideation expressed and nil other psychotic phenomenon evident".

24. On 15 March, the deceased was seen by Ms Sheena Neil, a psychologist who had been asked to undertake a comprehensive risk assessment and to make referrals to support services as required. At that time the deceased admitted that he had probably self harmed in the past, but he declined to talk about it, and denied any current wish to harm himself. Ms Neil referred him to Forensic Mental Health for further assessment, prison medical services for dental issues and prison treatment services for inclusion in a stress management program if one was available.

25. On 14 May 2010, Bird was placed "at risk" because he was refusing to take his medication and had made comments to a nurse that raised concerns that he might self harm. He was taken off risk on 15 May by a psychologist who noted that he was "just angry and unhappy", but his mood and effect were appropriate and he was cooperative, with no formal thought disorder and no perceptual problems.

26. On 9 October, the deceased put in a formal complaint using the "Superintendents' Parade Request Form", expressing frustration that he had not been allowed to do an anger management course. It appears that he had been told that his security rating was too high to enable him to participate in such a program.

27. This complaint was addressed efficiently and arrangements were made for a psychologist, Mr Elliot Becker, to conduct stress and anger management counselling for the deceased over a period of weeks. Between 18 October and 30 November 2010, Bird participated in individual psychotherapy sessions aimed at addressing his aggressive behaviour to help him function in the Court and custodial setting. Although some of those sessions were positive, on the last occasion the session was terminated when Bird became extremely hostile and described the process as a "waste of time". Mr Becker wrote him a letter inviting him to make contact again if he wished to resume the counselling and letting the deceased know that he was willing to continue to work with him.

28. Mr Becker gave evidence before me and I was impressed with the compassion he showed towards the deceased and the patient attempts he made to establish a therapeutic relationship.

29. On 10 January 2011, Bird made a request through the Darwin Correctional Centre for a money order to the value of $50,000 to be made out to his best friend, Gail Moody. He made a phone call to Ms Moody around that time where he spoke of wanting to send her a substantial amount of money that she could safeguard for him.

30. Although the deceased did not suggest to Ms Moody that he was giving away his money permanently and did not hint at self harming, prison staff were concerned enough to send a psychologist to check on his welfare. On 13 January 2011, psychologist Sheena Neil, spoke to the deceased at the request of James Sizeland, Director of Operations. She explained that she

was checking on his welfare and told him that there were concerns that he was giving away his money. Ms Neil had intended to do a risk assessment for the deceased, but he refused to participate, telling her that he could give his money to whomever he wished and he was not suicidal.

31. It appears that on a number of occasions, the deceased told medical staff that he would take his own life at a time and place of his choosing and that nobody would be able to stop him when he decided to do. Nevertheless, there were no indicators that he would self harm at any particular time. In fact, Mr Becker noted that the deceased exhibited some protective factors, given that he had some plans for the future concerning his court case.

Treatment of physical health issues whilst in custody

32. I have already referred to some of the physical heath problems that the deceased had when he came into custody, as recorded by Dr Mathison on his admission.

33. His most significant problem was his HIV and related health issues, which were managed by staff from Clinic 34, in particular Dr Pell and Dr Ryder. On occasions in March and June 2010, the deceased refused to comply with his anti retroviral (ARV) medication for a period, but was eventually persuaded to take it again. In November 2010, he refused to take ARV medication for the final time and he could not be coaxed back on it again, in spite of the attempts staff made to warn him of the adverse health impact.

34. Comments made by the deceased around the time he refused medication in November prompted Dr Mathison to review him and to question whether he was depressed. When Dr Mathison asked Bird if he wanted to hurt himself, he replied aggressively “Mate, I’ve wanted to hurt myself for 20 or 30 years”. Dr Mathison gave evidence that he did not interpret this to mean that

the deceased was at risk of self harm, but merely that he was angry and irritable and that statements such as this were a way of coping with his illness.

35. The deceased made a number of formal complaints about the health care he was receiving. They related to several issues that frustrated him, including that he was supposed to receive his ARV drugs at 12 hour intervals and the second dose would sometimes come an hour or so late, that tablets for gastro hadn't been on the medical trolley so he had put up with diarrhoea all day or that his supply of the nutritional supplement Sustagen was late or missed. I have reviewed the response to these complaints and I am satisfied that they were dealt with promptly. Although no system of health care for prisoners will be perfect, it appears that the efforts to provide the deceased with mental and physical health care were appropriate and sensible.

The event of 19 January 2011

36. On 19 January 2011, shortly after 9.00 am, the deceased and a fellow prisoner, Esau Hodgson, were tasked with the job of making tea for all persons in C Block. According to Hodgson, the deceased appeared angry that day and made it clear that he wanted to be left alone saying words to the effect of "I want to fuckin do this tea by myself today". Hodgson explains that every other time they've been there making tea together "he's all good and talked and he was all right". Mr Hodgson agreed to leave him to it and he departed the kitchen area, telling a prison officer on the way out that Bird was "a bit upset at the moment".

37. Prison Officer Matthew James gave evidence that he was the one who let Mr Hodgson out of the kitchen area that morning. His recollection of the brief conversation they had at the time was slightly different, in that he believes that he was simply asked by Mr Hodgson to be let out and was told that the deceased "was right in there". It is not possible to determine what words

were said at the time, but I am not troubled by the difference in the evidence given. Both witnesses appeared to me to be frank and I am satisfied that they were both trying to give me a truthful account of what occurred. Regardless of what was said, there was nothing to alert Mr James that the deceased was at risk of self harm. The deceased had made the tea for prisoners on his own on other occasions, and he presented as being in reasonable mood that morning, tidying his cell and even making a joke with Officer Bonson.

38. At some stage after Mr Hodgson left the kitchen, Bird took from his pocket a length of sheet that had been torn from his own bed sheet and secreted in his pocket, he exited the kitchen through the rear door and entered the concreted yard. He put a disused hot water urn on top of a nearby chair and climbed up on both. He fitted the noose around his neck and attached it to the top of the barrier located on the yard and then he hung himself.

39. Several prisoners outside the caged area saw what he was doing and shouted out to him not to "do it". One of those prisoners was Mr Eric Gurruwiwi, who alerted prison guards to what had occurred at approximately 9.43 am.

40. Prison Officers James and Bonson quickly arrived on the scene. Officer Bonson lifted the deceased up to take the pressure from around his neck and Officer James cut the noose with a Hoffman knife that had been retrieved from the emergency cabinet of the office at the sound of the alarm. Prison Officer Lovegrove later attended to assist with cardio pulmonary resuscitation ("CPR"), followed by other officers.

41. A Code Amber (used to indicate that an officer is hurt) was initially called by mistake, but it was almost immediately followed up by a Code Blue (signalling a medical emergency). Nurses Melanie Buscal, Sharon Calgaret and Margaret Campbell-Low attended very promptly, followed by Dr Mathison.

42. CPR was commenced by prison officers before medical staff from the prison health clinic arrived. Dr Mathison, who has worked within the prison system for three years and must have had ample experience in revival techniques, described the CPR as "the best I've ever seen". By the time the paramedics arrived, the deceased was breathing (albeit irregularly), he had a heart beat and his oxygen saturation levels were 100 per cent.

43. Ambulance staff received the job at 9.52 am and the first team of two officers arrived at 9.57 am. Another team of three officers arrived soon afterwards. It is clear therefore that the response of the prison officers, nursing staff, medical staff and ambulance officers was exemplary and they should be congratulated for it.

44. Despite their efforts, the deceased never regained consciousness. He was transferred to Royal Darwin Hospital and he died at 1.20 pm following day.

Conclusion

45. After hearing the evidence of prison officers that there was no CCTV in the courtyard area where the deceased hung himself, I considered whether to make a recommendation that cameras be put in the kitchen and courtyard area. However I am now persuaded that this may not be the most efficient use of resources. The issue of CCTV coverage was put to Kenneth Middlebrook, the Executive Director of NTCS. He made the point that this was the first prisoner who has attempted self harm in a public place like the courtyard area. Furthermore, with the new prison being built there are many demands for resources and CCTV in this area would not seem to be the best use of those funds.

46. Once again, Mr Middlebrook has given impressive and persuasive evidence. I join with him in wanting a new prison with state of the art facilities for prisoners. That will hopefully include new designs with minimal hanging points in rooms and recreation areas, adequate CCTV coverage of areas

outside cells and programs and facilities that will occupy prisoners and meet their needs. The sooner that new complex is built the better. I do not intend to recommend that resources be diverted in the meantime.

47. 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 identity of the Deceased person was Bird born on 6 February 1964. The Deceased was a prisoner at Darwin Correctional Facility, in the Northern Territory of Australia.

(ii) The time and place of death was 1.20 pm on 20 January 2011 at Royal Darwin Hospital.

(iii) The cause of death was intentional self inflicted hanging.

(iv) Particulars required to register the death:

1. The Deceased's name was Bird.

2. The Deceased was of Caucasian descent.

3. The Deceased was unemployed.

4. The cause of death was self inflicted hanging (suicide) and was reported to the coroner.

5. The cause of death was confirmed by post mortem examination carried out by Dr Sinton.

6. The Deceased's parents are Irene Eva Clarke and Alfred Ernest Clarke.

Dated this 25th day of November 2011 _____

GREG CAVANAGH
TERRITORY CORONER