CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Thompson James Harvey**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2017/5056
DELIVERED ON:	13 May 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 September 2019, 19-20 April 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, domestic violence, death in custody, hanging, substance misuse, symptoms of withdrawal, suicide, risk assessment.

REPRESENTATION:

Counsel Assisting:	Mr J Crawfoot
Queensland Corrective Services:	Ms A Bain, instructed by QCS Legal Strategy and Services

Central Queensland Hospital
and Health Service: Ms J Marsden, instructed by CQHHS

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Introduction

1. Thompson Harvey died on 13 November 2017, aged 33 years. Mr Harvey died while he was remanded in custody at Capricornia Correctional Centre (CCC) for a number of serious offences, including the serious assault of a police officer, attempted robbery and attempted murder.

2. Those offences were alleged to have been committed on 31 October 2017. They arose from a single course of conduct in which Mr Harvey was in possession of a firearm. That course of conduct resulted in a police operation and foot pursuit. He was located by police and it was reported that he fired several shots at the attending police. Mr Harvey was found with a self-inflicted gunshot wound to his head.

3. Mr Harvey survived the gunshot wound. He was admitted to Mackay Hospital on the same day and placed in an induced coma. The only surgical intervention required was a washout of his scalp, removal of bullet fragments (superficial to the skull), and analgesia.

4. On 2 November 2017, Mr Harvey was arrested in relation to the alleged offences. He was discharged from the Mackay Hospital to the Mackay watchhouse on 5 November 2017.[1]

5. On 7 November 2017, Mr Harvey was transferred from the watchhouse to the CCC where he was initially placed at the Health Centre and underwent hourly observations.

6. On 9 November 2017, Mr Harvey was transferred from the Health Centre to unit accommodation.[2] At 1:41pm,[3] Mr Harvey was received at Secure Unit 5 (S5) and placed in cell 1A.[4]

7. At about 7:40am on 13 November 2017, Mr Harvey was located deceased, hanged in his cell at S5. Mr Harvey had fashioned a ligature from bedding. A suicide note was located in the cell, addressed to his partner, Ms Wardlaw. Another two discarded suicide notes were located in the toilet.

8. There was no effective aid that could be provided to Mr Harvey and he was pronounced life extinct at 7:52am

9. On 14 November 2017 Mr Harvey's partner, Ms Wardlaw, expressed concern that his death was preventable. Similar concerns were expressed by Mr Harvey's family in New Zealand. Ms Wardlaw said:[5]

   "*It should have been identified that Tom posed an immediate risk of suicide due to the fact he had attempted to commit suicide directly before being taken into custody. My concern is that why wasn't Tom under suicide watch due to his history of self-harm and a history of substance abuse? I'm upset and angry*

[1] Exhibit E2 – Mackay Hospital – Records at p. 111/709.
[2] Exhibit D13.5 – Case notes
[3] Exhibit H1 – OCI-INSP-039 - Incident Investigation Report at T1.24
[4] Exhibit D24 – Secure Unit 5 Logbook
[5] Email dated 14 November 2017

because I feel this could have been prevented if correct risk management practises were implemented."

10. In summary, the family's concerns were:

    - the CCC was not informed of the suicide risks that Mr Harvey had presented with at Mackay Watchhouse or Mackay hospital, and this has affected the way that Capricornia psychologists assessed Mr Harvey's suicide risk; and
    - CCC medical staff had incorrectly assessed Mr Harvey's suicide risk and recommended inadequate observations of 60 and 120 minutes.

The Investigation

11. On 13 November 2017, a direction was given to the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) for a full investigation to be carried out.

12. Detective Sergeant Carr from the CSIU investigated the circumstances leading to Mr Harvey's death. His report was dated 26 April 2019 and was tendered at the inquest.

13. After being notified of the death CSIU officers attended CCC together with a scenes of crime officer. Mr Harvey's cell was inspected. A search of the cell revealed no suspicious circumstances. A fingerprint examination confirmed his identity.

14. CSIU detectives arranged the seizure of all prison records relating to Mr Harvey. They conducted interviews with other prisoners in his Unit at CCC. Statements were also obtained from corrective services staff, including the staff who conducted risk assessments for Mr Harvey on his entry to prison.

15. Detective Sergeant Carr stated that the primary focus of his investigation was to ensure 'adequate medical care' was given to Mr Harvey and there were no suspicious circumstances surrounding the death. He noted that Mr Harvey was under the supervision of health professionals at the CCC who had recommended he be maintained on 120 minute observations on the afternoon of 9 November 2017 under an At Risk Management Plan. There was no evidence that this had not been adhered to.

16. Detective Sergeant Carr reported that the cells in the CCC are designed to be a safe place to detain prisoners with minimal physical contents to minimise any self-harm actions. The cell door between the cell and the common area of the Unit was usually kept closed throughout the day and the inmate locked in the cell overnight. He was satisfied adequate care had been provided and there were no suspicious circumstances in relation to the death.

17. A parallel investigation was conducted by the Office of the Chief Inspector (OCI) in QCS. Those investigators prepared a very comprehensive report, dated February 2019, which was also tendered at the inquest.

18. While no individual causal factor to Mr Harvey's death was identified in the OCI Report, a number of "systems practice improvements" were recommended to minimise the risk of future incidents. The OCI Report identified 20 findings and contained 26 recommendations in relation to addressing those findings.

19. The findings of the inquest are broadly consistent with those of the OCI investigation. However, the inquest had the benefit of additional evidence from the QPS, CQHHS and experts briefed by the court in relation to forensic toxicology and suicide risk assessment.

The Inquest

20. As Mr Harvey died in custody, an inquest was required by the *Coroners Act 2003*.

21. A pre-inquest conference was held on 17 September 2019. At the pre-inquest conference it was identified that a range of further evidence, including additional witness statements and expert reports, were required before the inquest could proceed.

22. It had also been proposed that Mr Harvey's family from New Zealand might travel to Australia for the inquest. This was not possible during the Covid-19 pandemic.

23. The inquest was held at Brisbane on 19-20 April 2023. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

24. Leave to appear was granted to Queensland Corrective Services (QCS) and the Central Queensland Hospital and Health Service. Staff members from who had interviewed Mr Harvey on his entry to prison gave evidence, together with custodial staff.

25. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

26. The issues for inquest were:

    a) The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

    b) Whether the authorities charged with providing for Mr Harvey's mental health and physical care at the Capricornia Correctional Centre prior to his death adequately discharged those responsibilities.

    c) Whether the mental health assessments conducted of Mr Harvey upon his induction and prior to his death at the Capricornia Correctional Centre were appropriate.

    d) Whether the placement of Mr Harvey and the frequency of the observations conducted while he was an inmate at the Capricornia Correctional Centre were sufficient.

    e) Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The Evidence

Personal History

27. Mr Harvey was a New Zealand citizen, with Australian residency. He travelled to Australia to work in the mining industry in 2011 and lived in Mackay with his partner. Mr Harvey had a New Zealand criminal history, which he reported consisted of violent offences, including non-aggravated robbery, for which he had been imprisoned for in New Zealand. He was survived by a son, aged 10. I extend my condolences to Mr Harvey's family and friends.

28. Mr Harvey's Queensland criminal history commenced in January 2015 when he was aged 30. That history consisted initially of weapons related offences in 2015 and early 2016, for which he was fined. His offending progressed in 2016 and 2017 to drug and theft related offences including possessing dangerous drugs (and utensils), breaking and entering, stealing and possessing stolen property. For the latter offences, Mr Harvey was sentenced to probation orders in July 2016 and September 2017.

History of Substance Misuse and Withdrawal

29. At about 10:45am on 2 November 2017, Mr Harvey was ceased on sedation and extubated at the Mackay Hospital. After regaining consciousness, he was aggressive and agitated. He disclosed suicidal ideation and was identified by a hospital intern, Dr Tan, as being at risk of withdrawal due to his "*regular morphine and ICE use*". He was admitted to the ICU at this time.

30. After being ceased on sedation and extubated, Mr Harvey was arrested and charged by the QPS in relation to the events of 31 October 2017. His offending conduct had occurred in the context of a relationship breakdown. He disclosed his use of illicit substances (methamphetamine, amphetamine, heroin and morphine) then escalated.[6] His history of poly-substance drug abuse was documented as early as 2012.[7]

31. Mr Harvey had a previous suicide attempt on 14 April 2014, when he took an overdose of Seroquel (400m) also in the context of a relationship break down.[8] Mr Harvey's partner at this time was A, with whom he shared a son, M.

32. Mr Harvey commenced using methamphetamine at age 17 and was intravenously using half an "*eight ball*" per day.[9] He commenced using morphine at age 24, which he also administered intravenously, at the rate of 100mg per day.[10]

33. Mr Harvey self-disclosed having last used drugs on 31 October 2017.[11] This self-disclosure is consistent with the admission toxicology sample taken at 9:51pm that night, which confirmed the presence of amphetamines and benzodiazepines (but not morphine).[12]

[6] Exhibit E2 – Mackay Hospital – Records at T1.125, T1.680
[7] Exhibit E2 – Mackay Hospital – Records at T1.669, T1.652
[8] Exhibit E2 – Mackay Hospital – Records at p. 41, 78, 103/709
[9] Exhibit E2 – Mackay Hospital – Records at T1.616, T.667
[10] Exhibit H4 – IRNA 2017-11-07 T1.3
[11] Exhibit H4 – IRNA 2017-11-07 T1.3
[12] Exhibit E2 – Mackay Hospital – Records at T1.294

34. Mr Harvey's history of "*regular morphine and ICE use*" formed the basis of the risk assessment completed by Dr Tan. On 2 November 2017, Dr Tan identified withdrawal from substance use as a risk factor and commenced Mr Harvey on 10mg morphine (MS Contin) to manage that risk.[13] That was to be administered twice each day.

35. On 3 November 2017, Dr Tan also commenced Mr Harvey on Oxycodone (5mg) for pain. That was to be administered four times per day, a total of 20mg per day.[14]

36. A review of Mr Harvey's medication chart from the Mackay Hospital confirmed he was administered morphine and Oxycodone (as prescribed) for the duration of his admission.

Opiate Withdrawal?

37. Mr Harvey's risk of suicide was identified as requiring management on his discharge from the Mackay Hospital to the watchhouse.

38. On 3 November 2017, Dr Rana completed a Mental Health Assessment with Mr Harvey. While it identified risk of suicide as 'high' and risk of vulnerability to polydrug dependency as 'high', the assessment and subsequent plan were silent on concerns around the risk of withdrawal and how that should be managed.

39. At about 5:16pm on 3 November 2017, Mr Harvey was discharged from the ICU to wards.[15] His ICU discharge summary documented medications as including MS Contin "*for opiate withdrawal*". This was the last occasion his prescription for MS Contin was linked to opiate withdrawal.

40. On 5 November 2017, Dr Henderson medically cleared Mr Harvey for discharge to the watchhouse. His progress notes identified persistent suicidal ideation as a risk but did not refer to the risk of withdrawal. Mr Harvey was also asking for medication:

> "*He was requesting some medication to help him feel better. I discussed with him that I thought he was experiencing an acute reaction to the end of the relationship, his subsequent actions and the impending consequences and as such there was no medication that would help resolve his current feelings. It is likely that the passage of time will be the only thing that will be helpful. Mr Harvey was unhappy with this saying I would be responsible for his death if he killed himself.*"

41. Dr Henderson agreed with a QPS suggestion that a safety plan be implemented whereby Mr Harvey would be placed in a padded cell, with an anti-ligature smock, under constant video surveillance.[16]

[13] Exhibit E2 – Mackay Hospital – Records at T1.503
[14] Exhibit E2 – Mackay Hospital – Records at T1.499
[15] Exhibit E2 – Mackay Hospital – Records at T1.121
[16] Exhibit E2 – Mackay Hospital – Records at T1.110

42. A QPS Prisoner Medical Transfer, Treatment and Clearance Sheet, was completed by Dr Chan.[17] It identified suicide as a 'Known Warning' but did not refer to any issues associated with withdrawal from illicit substance use. Dr Chan also completed a Prisoner Medical Clearance Sheet that identified Mr Harvey's medication as follows:[18]

- Cephalexin, 250 mg, 4 times/day
- MS Contin, 10mg, 2 times/day
- Levetiracetam, 750mg, 2 times/day

43. With regards to any 'specific instructions for police', Dr Chan stated "*Nil*".

44. While Dr Chan documented Mr Harvey's discharge medications correctly, relevant information in relation to MS Contin was not transcribed.

45. A review of Mr Harvey's discharge summary identified the Cephalexin was prescribed to treat his head wound. Levetiracetam was prescribed for 'seizure prevention'. The discharge summary did not identify why the MS Contin was prescribed. Under 'Reason', it was only stated: "*review after 10 days for appropriateness of continuation*".

46. The discharge summary did not identify that MS Contin had been prescribed to manage the risk posed to Mr Harvey of withdrawal from morphine.

47. The discharge summary was also silent on the Oxycodone prescription. However, it appears that Oxycodone was ceased before Mr Harvey's discharge. The last dose of Oxycodone administered to Mr Harvey was at 12:05pm on 5 November 2017.[19]

48. On 6 November 2017, Mr Harvey was reviewed in the watchhouse by Community Liaison Officer, Kaitlin Radloff. That review was silent on any consideration of managing Mr Harvey's withdrawal symptoms, although that was likely due to the limited documentation regarding that issue. The substance abuse and addictive behaviours checklist was not completed.

49. CLO Radloff's progress note confirm she had access to Mr Harvey's hospital records, but it seems that was only for the purpose of obtaining a social history.[20] Those records disclose the prescription for 'morphine' but not the reason it was prescribed. There were features in his presentation that brought CLO Radloff to conclude that Mr Harvey was experiencing an '*Acute Stress Reaction'* although it would have been relevant to consider if his presenting symptoms might also be consistent with morphine withdrawal.

[17] Exhibit C11 – QPS Prisoner Medical Transfer, Treatment and Clearance Sheet T1.1
[18] Exhibit C11 – QPS Prisoner Medical Transfer, Treatment and Clearance Sheet T1.3
[19] Exhibit E2 – Mackay Hospital – Records at T1.311
[20] Exhibit E2 – Mackay Hospital – Records at T1.696

50. As to the risk of suicide, CLO Radloff commented:

> "*The risk of suicide is mitigated by the watchhouse context and Thompson's inability to access means to harm himself. Thompson has expressed ongoing suicidal ideation with nil direct indication of plan or intent. The risk could further be mitigated by transfer to the padded cell from the observations cell if Thompson did express or display plan or intent.*"[21]

51. A review of Mr Harvey's watchhouse medical records confirmed he was administered MS Contin at 6:32pm on 5 November 2017, then 9:05am and 6:31pm the following day. He was not given MS Contin on the morning of 7 November 2017, the day of his transfer to CCC.

52. A review of Mr Harvey's property records from the watchhouse and CCC did not identify his medication as part of his property.[22]

53. In addition, on 6 November 2017, Clinical Coordinator and Senior Social Worker for the Prison Mental Health Team, Ms Sharlene Dodds, identified that Mr Harvey was due to arrive at CCC the next day.[23] She also identified that two Consultant Psychiatrists at the Mackay Hospital had assessed Mr Harvey. This was a reference to the assessment completed by Dr Rana and Dr Tedja on 3 November 2017.[24]

54. That assessment discussed suicide risk and polysubstance dependency. It did not refer to morphine withdrawal and the extent to which that required ongoing management, likely because the self-report of Mr Harvey did not match his admission blood screen.

55. Ms Dodds sent an email to Offender Health Nurse Unit Manager, Mr Alan Wentworth, and Senior Corrective Services Psychologist, Ms Kay Hanschen, providing a summary of that assessment.[25] That summary indicated Mr Harvey had "*no major mental illness but had been assessed as having ongoing suicide risk*".

56. At approximately 9:19am on 7 November 2017, Mr Harvey was transported from the watchhouse to the CCC.[26] When Mr Harvey was received into the CCC he underwent an Immediate Risk Needs Assessment (IRNA) with Natasha Kann. The assessment completed by Ms Kann identified that no "*at-risk*" information was provided by officers that had transported him to CCC.[27]

57. The IRNA documented Mr Harvey's history of substance use (self-disclosed) and past suicidal ideation. Mr Harvey denied having any active suicidal ideation. The assessment completed by Ms Kann formed the basis of a referral to a psychologist.[28] That referral noted Mr Harvey was prescribed Endone for pain.

[21] Exhibit E2 – Mackay Hospital – Records at p. 703/709
[22] Exhibit C12 – QPS Prisoner Property Sheet and Exhibit D13.8 – Property
[23] Exhibit B22 – DODDS, Sharlene at T1.1, paragraph 6
[24] Exhibit E2 – Mackay Hospital Records at T1.680
[25] Exhibit B22 – DODDS, Sharlene at T1.1, paragraph 6
[26] Exhibit C10 – QPS Person Report (Custody) - HARVEY
[27] Exhibit H4 – IRNA 2017-11-07 T1.5
[28] Exhibit H4.1 – IRNA Referral 07.11.2017

58. At 10:20am on 7 November 2017, an 'Initial Assessment At-Risk Prisoner'[29] was completed with Mr Harvey by Provisional Psychologist, Abby McMurtrie. He was described as 'irritable' in the context of withdrawal from methylamphetamine and morphine. Mr Harvey also self-disclosed his suicide attempt of 31 October 2017. Mr Harvey presented with symptoms consistent with illicit substance withdrawal.

59. At 10:36am on 7 November 2017, Ms Radloff sent an email to Ms Dodd, regarding Mr Harvey's transfer to CCC.[30] That email was silent on any issue regarding morphine withdrawal but drew attention to the risk of suicidal ideation.

60. At 11:00am on 7 November 2017, Clinical Nurse, Amanda Nunn, completed a Prison Health Service (Medical-In-Confidence) review with Mr Harvey.[31] That review confirmed his prescription and dose of MS Contin. However, it did not disclose the reason for its prescription, and stated that it was to cease on 10 November 2011.

61. The review confirmed Mr Harvey was prescribed daily opioids. When prompted to document if Mr Harvey was a patient being treated for opioid dependence, CN Nunn endorsed "*no*". Notwithstanding that endorsement CN Nunn concluded by identifying that Mr Harvey was "*withdrawing from morphine*", the required action for which was to reduce his Valium regime.[32]

62. During that consultation Mr Harvey self-disclosed "*his main concern is his morphine withdrawal*". CN Nunn noted his current prescription is for "*10mg BD finishing on the 10/11/17*". However Mr Harvey disclosed the prescription was "*not working at all. Needs ↑100mg to be effective. Usually has 100mg daily dose for addiction*".

63. Mr Harvey's prison medication chart, as completed by Dr Davies, had Mr Harvey commenced on MS Contin (from 7 November 2017 until 10 November 2017) to treat his "*gunshot wound*". Thereafter, he was to be commenced on Diazepam and Buscopan (from 11 November 2017 until 25 November 2017) to treat his morphine withdrawal and associated stomach cramps.[33] The decision to cease Mr Harvey on MS Contin was likely made before 11:00am on 7 November 2017.[34]

64. There was an apparent misunderstanding of the purpose for which Mr Harvey was prescribed MS Contin. On the one hand, CN Nunn understood it was to treat morphine withdrawal, yet the purpose of the prescription as completed by Dr Davies had it to treat the gunshot wound, and the pain that may have been associated with it.

65. It is not clear what informed Dr Davies' decision to cease Mr Harvey on MS Contin on 10 November 2017. Dr Davies' discharge summary, which included the prescription for MS Contin, formed part of his Prison Medical File. On that basis, it might be inferred that Dr Davies had knowledge of the original prescription but not the reason for it.

[29] Exhibit H5 – Initial Assessment At Risk Prisoner - 2017-11-07
[30] Exhibit E2 – Mackay Hospital Records at p. 706-707/709
[31] Exhibit E8 – E81398 PHS Vol 1 IM at T1.9 and T1.21
[32] Exhibit E8 – E81398 PHS Vol 1 IM at T1.15
[33] Exhibit E8 – E81398 PHS Vol 1 IM at T1.75
[34] Exhibit E8 – E81398 PHS Vol 1 IM at T1.85

66. Nonetheless, Dr Davies' treatment suggests a fresh medication regime, rather than a continuation of the regime Mr Harvey was commenced on at the Mackay Hospital. There was no evidence of an additional enquiry being made with the Mackay Hospital to understand the basis of his discharge treatment plan.

67. While the Discharge Summary did not inform the basis of the MS Contin prescription, it required that it be reviewed after 10 days. Whether the 10 days was to commence from first prescription (3 November 2017) or the date of discharge (5 November 2017) is also unclear. In any event, it should have been reviewed no earlier than 13 November 2017.

68. From 11 November 2017, the gunshot wound pain was to be managed with Panadeine.

69. Notwithstanding Diazepam and Buscopan being prescribed to continue management of morphine withdrawal, Mr Harvey's prison medication chart identifies he only received Diazepam on two occasions, 7 November 2017 (3:00pm) and 8 November 2017 (8:00pm).[35] The same chart does not identify any Buscopan having been administered to Mr Harvey during his period of incarceration.

70. To assist consideration of this issue, the Coroners Court obtained an expert report from Professor Olaf Drummer, Forensic Toxicology Consultant Specialist, in relation to Mr Harvey's withdrawal from opiates at the time of his death.[36]

71. Professor Drummer concluded that he was not convinced Mr Harvey was suffering from any opiate withdrawal effects in the days prior to his death.

72. Professor Drummer noted that while Mr Harvey reported prior heavy morphine use, there was no independent evidence to verify this, "*let alone how he was able to access a regular supply of high dose morphine*". Mr Harvey self-disclosed having last used drugs on 31 October 2017. An admission toxicology sample taken at 9:51 pm that night, confirmed the presence of amphetamines and benzodiazepines. No morphine was detected.

73. Notwithstanding, Professor Drummer said that he was prescribed a sustained release form of morphine (MS Contin) 10 mg twice daily, a much lower dose than he had claimed he was using regularly. This would also have relieved some of his pain from his head injury.

74. On his discharge from hospital on 5 November 2017, he was transferred to the watchhouse and the CCC with no apparent indication that he needed medication. Professor Drummer said the symptoms described most relevant to possible opiate withdrawal effects such as slight irritability and restlessness "did not seem particularly severe, and would not have been life-threatening".

75. Professor Drummer said assessments at the CCC on 9 November 2017 did not indicate Mr Harvey was exhibiting any unusual behaviours or symptoms relevant to possible opiate withdrawal. His morphine was stopped on 10 November 2017 and replaced by Panadeine forte. The dose of the Panadeine forte was two tablets twice daily (60 mg of the opiate codeine twice daily) which would be equivalent to about 6-10 mg morphine twice daily.

[35] Exhibit E8 – E81398 PHS Vol 1 IM at T1.79
[36] Exhibit I2, dated 19 December 2022.

76. Professor Drummer noted that Mr Harvey complained of being in pain and CCC was driving him mad. These symptoms, if they were true, are not classical signs associated with morphine withdrawal. If he had been taking 100 mg morphine daily, it would be expected that he would have developed symptoms associated with morphine withdrawal within a day of ceasing his drug use.

Assessment of Suicide Risk at CCC

77. Ms McMurtrie was aware Mr Harvey was experiencing suicidal ideation during the remand period before his arrival at CCC. Ms McMurtrie documented the following interaction:

    "*The prisoner denied any current suicidal ideation, plan or intent and stated the above incident was the last time he experienced suicidal ideation. He stated "I didn't die this time, so there must be a reason for me to be alive"*"

78. Ms McMurtrie considered that disclosure was inconsistent with his remand history and was cognisant of the attempted suicide by overdose in 2014. During this assessment Mr Harvey also disclosed experiencing "*10/10*" anxiety. Ms McMurtrie identified her report was incomplete, as she was unable to do a full assessment due to Mr Harvey's presenting state.

79. The OCI Report noted that while Ms McMurtrie believed that Mr Harvey had protective factors, including that he had reconciled with his partner, no collateral checks were carried out to identify whether there was any truth to this assertion.

80. The OCI Report found that the "automated use of the standard words and practices of cutting and pasting may be erroneous and may have the very real potential to mislead. Indeed, on this occasion, there were no, or insufficient, protective factors outlined by Ms McMurtrie due to the incompleteness of her initial assessment, which continued into the assessments of the RAT team that followed".

81. The OCI Report concluded that Ms McMurtrie's assessment did not provide sufficient information in the form of protective factors and as to how those factors sufficiently balance and significantly moderate his risk levels to support the decision to place Mr Harvey on medium observations.

82. Having regard to the conclusions in the OCI Report, Forensic Psychologist, Dr Gavin Palk, provided an expert opinion to the Coroners Court in relation to the risk assessments carried out at the CCC.

83. Dr Palk concluded Ms McMurtrie complied with all the Corrective Services' protocols and procedures in undertaking the risk assessment. He noted it may have been prudent for Ms McMurtrie to have undertaken collateral checks with Mr Harvey's partner and relatives to ensure he had emotional support and was connected to his family.

84. It was not clear to Dr Palk what protective factors were present, apart from the fact Mr Harvey reported he had reconciled with his partner and indicated he had support from another prisoner. Dr Palk said if other collateral information were available, it would have been prudent to assess Mr Harvey as a high risk initially and place him on 15 minutes observations.

85. Based on the information available, Mr Harvey was identified as medium risk of self-harm or suicide. This required 60-minute observations and appropriate accommodation. On 7 November 2017, Ms McMurtrie made a 'Notification of Concern' to Ms Debra Davis, Correctional Supervisor.[37]

86. Based on that Notification, Ms Davis completed an Initial Response Plan, requiring that Mr Harvey be placed on 60-minute observations, with conditions that he be provided suicide resistant clothing and suicide resistant bedding.[38] Those conditions were subsequently removed during a risk assessment meeting, held two days later.

87. At 10:59am on 7 November 2017, Mr Harvey was placed on a Safety Order[39] which required that he be segregated from the main prison population.[40] The Safety Order was due to expire on 4 December 2017. Because of the Safety Order, Mr Harvey was to be reviewed by a doctor or psychologist as soon as practicable after it was made.

88. On 8 November 2017, a weekly interagency meeting between Offender Health Services, Queensland Corrective Services psychologists and Prison Mental Health staff occurred. Mr Harvey's case was discussed.[41] The PMHS triage guidelines were used to determine Mr Harvey's level of priority. It was determined that PMHS would review Mr Harvey the following week.[42] He died before that review.

89. At 8:00am on 9 November 2017, Psychologist, Stephanie Haddock, assessed Mr Harvey. During that assessment Mr Harvey denied any current suicidal ideation and said his previous suicide attempts coincided with methylamphetamine use.

90. He also informed Ms Haddock that he had reconciled with his partner. On the basis of this assessment, Mr Harvey's risk profile was reduced from 'Medium' to 'Low'.[43] As a consequence of this, Mr Harvey's observation cycle was reduced from 60 to 120 minutes. Ms Haddock did not make any other recommendations.

91. Prior to the RAT meeting, Custodial Supervisor Clark also undertook an independent assessment of Mr Harvey and recorded his assessment in the At-Risk Assessment Report form. When interviewed by OCI Inspectors, CS Clark remarked that an At-Risk Assessment took him between 5 to 10 minutes per prisoner and that when he conducted his assessment of Mr Harvey, he:
    - Examined IOMS
    - Examined the prisoner's case notes
    - Spoke to Health Centre staff members as to the behaviour of Mr Harvey
    - Questioned Mr Harvey on each relevant topic listed in the Administrative Form 64 - At-Risk Assessment Report
    - Observed Mr Harvey's behaviour.

[37] Exhibit H6 - Notification of Concern 2017-11-07
[38] Exhibit H7 - Initial Response Plan 2017-11-07
[39] Exhibit H16 - Safety Order 2017-11-07
[40] Exhibit H47.1 - ROI - Arthur ASPINALL at T1.2/4-13
[41] Exhibit B22 – Statement of Sharlene Dodds at para. 11
[42] Exhibit B22 – Statement of Sharlene Dodds at T1.1, paragraph 11
[43] Exhibit H8 - At Risk Assessment - Psychologist

92. CS Clark assessed Mr Harvey was a low risk. His recommendation was 'Reduce to 120 minute Observations'. The OCI Report concluded that "*the At-Risk Assessment Report completed by CS Clark was not completed thoroughly and lacked sufficient information*".

93. During the Risk Assessment Team Meeting at 1:00pm on 9 November 2017, Senior Psychologist, Kay Hanschen, endorsed the decision and revised the observation cycle.[44] The Safety Order was subsequently cancelled in IOMS by A/DGM Aspinall at 1:52 on 9 November 2017.

94. That decision was made with regard to the balance of risk and protective factors. The notes from the meeting minutes did not specify what those protective factors were, however, consideration was given to:

    a) Mr Harvey's self-reported mood was "good";
    b) Mr Harvey was appropriately engaged with the assessment process;
    c) Mr Harvey denied any experiencing depression at the time of the assessment;
    d) Mr Harvey denies any symptomology associated with psychosis;
    e) Mr Harvey denied any feelings of hopelessness;
    f) He was future-focussed and aimed to resume his relationship and find employment;
    g) He was open to receiving further assistance from the treatment team;
    h) He identified his partner as his primary external support

95. Dr Palk, was critical of these conclusions. In his report he said:

    "*it [is] difficult to believe that Mr. Harvey did not have any welfare needs or major psychological problems considering he had recently made a very serious attempt to kill himself and there were reports of at least two prior suicide attempts (overdose on pills in 2014 and attempted hanging prior to 2011) related to relationship breakdowns coupled with his history of poly-substance misuse and antisociality*"[45]

96. Ms Hanschen told the inquest that Mr Harvey's history required that he be placed on at least 60 minute observations on entry to CCC. She was aware of what he had done and what had resolved with his relationship at that point. He expressed no suicidal ideation to CCC staff. The level of risk 'medium' more than adequately covered his presentation. She did not consider that CCC staff had any authority to conduct collateral checks. She also said there was no pressure on her or any other staff to reduce levels of risk from medium to low.

97. Ms Hanschen said that the RAT team considered the recommendation from the staff who had assessed Mr Thompson based on information they had obtained. She had no reason to alter that. The RAT team's decision was then taken to the General Manager for ratification.

[44] Exhibit H10 - Minutes of RAT Meeting 2017-11-09
[45] Expert report at 5.8

98. Dr Palk told the inquest he would not base his assessment on Mr Harvey's self-reports, given his pattern of behaviour and serious head trauma. He opined:

> "*The writer also finds it difficult to believe that Mr. Harvey's self-reported severe anxiety on 7th November 2017 would have resolved within two days by 9th November 2017 where he reports not experiencing anxiety, especially when there is no evidence of psychological treatment being provided to address the initial severe anxiety*"

99. Dr Palk agreed that his opinions were based on hindsight, and that suicidal ideation can be very unpredictable. He said Mr Harvey had suffered a significant head trauma and out of caution he would have left his risk level as medium on 9 November 2017.

100. Dr Palk's experience is that prisoners may lie about their mental state as they do not want to be in a smock and/or padded cell, or may be actively planning to suicide. You cannot just accept what they say when they have just attempted and have a pattern of attempts, relationship breakdown, and substance misuse. However, he also agreed that Mr Harvey's presentation may have been markedly different four days later on 13 November 2017.

101. An associated Risk Management Plan[46] documented the change in observations from 60 minutes to 120 minutes. The same plan did not endorse any conditions for:

    a) Cell search for self-harm instruments;
    b) Suicide resistant clothing; or
    c) Suicide resistant bedding.

102. The Risk Management Plan documented the following "*current factors*" that were considered to place Mr Harvey at risk of self-harm/suicide:

    a) *Significant suicide attempt via self-inflicted gunshot wound approximately one week ago;*
    b) *Denied any suicidal ideation, plan or intent since incident (inconsistent with information obtained from Prison Mental Health Services)*
    c) *History of suicide attempts;*
    d) *Rated current experience of anxiety as 10/10 with 10 being severe;*
    e) *Disrupted sleep cycle, an experience of vivid, "weird" dreams, and decrease in appetite*
    f) *Presented with symptoms congruent with illicit substance withdrawals including slight irritability, restlessness, short and limited response to assessor's questions, stumbling when standing and hunched body posture; and*
    g) *Unable to complete full assessment due to presenting state*

103. Those factors were copied verbatim from the Notification of Concern that had been completed by Ms McMurtrie two days earlier. It is not apparent whether all those factors were considered relevant as at 9 November 2017.

[46] Exhibit H11 - At Risk Management Plan 2017-11-09

104. With respect of 'illicit substance withdrawal', while there was a level of management in place that was due to cease the next day there is no evidence the Risk Assessment Team considered that aspect of Mr Harvey's treatment.

105. The Management Plan did not seek to reconcile the substantial difference in presentation between 7 and 9 November 2017. The Management Plan did not make any recommendations concerning a change to suicide resistant clothing or bedding.

106. Senior Social Worker, Ms Dodds, was not made aware of the changes made to Mr Harvey's observations cycle or housing.[47]

107. The OCI Report concluded that "*while it may not necessarily have led to a different decision, the RAT did not give reasonable consideration to Mr Harvey's placement in secure accommodation, including his request to be accommodated in the same unit as an identified peer"* in Unit S7. The Report noted that the COPD Risk Management provided that the RAT must:

> '*consider the suitability of the current or proposed cell accommodation for the prisoner (this includes determining the adequacy of cell infrastructure, any specific risks posed by the accommodation such as hanging points and if necessary, making recommendations to the centre to mitigate against risk posed by cell infrastructure)'*

108. Mr Harvey was placed alone in a cell in S5 because that was an induction unit. Dr Palk concluded that it would have been judicious to leave Mr Harvey on at least the medium risk level, particularly as there would have been adjustment problems associated with a change in accommodation status and no psychological treatment appears to have been provided to help him mange anxiety.

Observations of Mr Harvey

109. There are limited notes regarding Mr Harvey's physical presentation following his remand at CCC. There are no Observations Logs for the period between 7 and 11 November 2017.

110. Notwithstanding Mr Harvey being on 60-minute observations while placed in the Health Centre, there is limited material in relation to those observations. He was received into the Health Centre at 1:25pm on 7 November 2017.[48] An associated case note documented:

> "*Initially distressed at being placed into OBS but he soon settled and slept through the afternoon. Seen by the nurse at 14.55 and advised of his initial medication routine. Was then seen again in the afternoon BSL's for medication. Behaviours were acceptable and compliant at this time. Ate his dinner as provided. No issues to report.*"

[47] Exhibit B22 – Statement of Sharlene Dodds at para. 12
[48] Exhibit D13.5 – Case Notes at T1.1

111. It is possible that the reference to 'seen again in the afternoon' is a reference to an event at 3:00pm, when 'At Risk Observations' were made, identifying that nil treatment was required.[49] There is otherwise no indication of any physical symptoms Mr Harvey may have been experiencing.

112. Likewise, a case note dated 8 November 2017, documented the following:[50]

> "*Prisoner has spent most of his time sleeping today he has consumed all meals provided and been polite and compliant with all directions given to him. He requested something to read which I declined and explained he couldn't have due to being at risk. He had a shower at 1600. He was offered exercise but declined*".

113. At 8:30am and 3:30pm, 'At Risk Observations' were made, identifying that nil treatment was required.[51] There is otherwise no indication of any physical symptoms Mr Harvey may have been experiencing.

114. CCO Alan Flood told the inquest that he was working in the Medical Centre on 7 November 2017, looking after prisoners who were on observations. He said that Mr Harvey was distressed as he moved him to the observation cell and told him he would be required to change into a 'suicide gown'. Mr Harvey told him that he wanted to go to the accommodation blocks. CCO Flood informed him that he was required to be on hourly observations and he appeared to settle.

<u>10 November 2017</u>

115. On the morning of 10 November 2017, Mr Harvey refused his morning morphine dose.[52]

116. A case note dated 10 November 2017 (after Mr Harvey had been placed in S5) documented:[53]

> "*Prisoners behaviour and conduct in S5 has been satisfactory, Prisoner keeps his cell clean and tidy and appears to have no issues at present*"

117. Mr Harvey attended the Health Centre on 10 November 2017 to receive treatment for his gunshot wound. There is otherwise no indication of any other physical symptoms he may have been experiencing.[54]

118. Mr Harvey did take his evening dose of morphine on 10 November 2017.[55] This was the last time he was administered morphine.

<u>11 November 2017</u>

119. There are no case notes for 11 November 2017.[56]

[49] Exhibit E8 – E81398 PHS Vol 1 IM at T1.27
[50] Exhibit D13.5 – Case Notes at T1.1
[51] Exhibit E8 – E81398 PHS Vol 1 IM at T1.27
[52] Exhibit E8 – E81398 PHS Vol 1 IM at T1.77
[53] Exhibit D13.5 – Case Notes at T1.1
[54] Exhibit E8 – E81398 PHS Vol 1 IM at T1.32
[55] Exhibit E8 – E81398 PHS Vol 1 IM at T1.77
[56] Exhibit D13.5 – Case Notes at T1.1

120. No diazepam was administered to assist Mr Harvey with morphine withdrawal.[57]

121. At 1:15pm on 11 November 2017, the following progress note was made:

> "*Pt states pain 5/10, exudate ++ & "noise ! it's driving me mad!" Hx self-inflicted GSW [gunshot wound] to the head. OK nil tympanic membrane visible, appears to be completely blown. Interior ear & canal red, moist. (Pt had not been told to keep ear dry). Swabs collected. VMO to be notified …*"[58]

122. His medication chart indicates he was administered Codapane Forte (500mg/30mg) that morning although the timing of that dose was not noted.[59] Mr Harvey was also administered Codapane Forte in the evening. Again, the timing of the dose was not noted.

123. Mr Harvey's medication chart documents medication being administered (Amoxycillin) at 5:30pm and 10:00pm on 11 November 2017.[60] The Amoxycillin was to treat a middle ear infection. There were no associated notes concerning his physical presentation or mental health symptoms, although having regard to the progress note at 1:15pm he appeared to be experiencing a degree of psychological distress.

<u>12 November 2017</u>

124. A case note dated 12 November 2017 documented:[61]

> "*Prisoners behaviour and conduct in S5 has been satisfactory, Prisoner keeps his cell clean and tidy and regularly attends the gym.*"

125. At 2:20pm on 12 November 2017, the following progress note was made:

> "*NURSING:- Reception pathology escalated. R.O.S. [review of symptoms] to R) side of scalp. Requesting increase in pain relief – consulted Dr Davies. To remain on current Panadeine Forte*".[62]

126. The medical progress note that Mr Harvey was seeking an increase in his pain relief, appears inconsistent with the case not that he appeared to have no issues.

127. Medication charts for 12 November 2017 confirm he received Amoxycillin at 7:30am, 5:30pm and 10:00pm that day.[63] Paracetamol (1mg) was also administered at 10pm.[64]

128. Codapane Forte was administered morning and evening.[65]

[57] Exhibit E8 – E81398 PHS Vol 1 IM at T1.79
[58] Exhibit E8 – E81398 PHS Vol 1 IM at T1.22
[59] Exhibit E8 – E81398 PHS Vol 1 IM at T1.81
[60] Exhibit E8 – E81398 PHS Vol 1 IM at T1.82
[61] Exhibit D13.5 – Case Notes at T1.1
[62] Exhibit E8 – E81398 PHS Vol 1 IM at T1.22
[63] Exhibit E8 – E81398 PHS Vol 1 IM at T1.82
[64] Exhibit E8 – E81398 PHS Vol 1 IM at T1.83
[65] Exhibit E8 – E81398 PHS Vol 1 IM at T1.81

129. An observation log between 12 November 2017 and 13 November 2017, confirmed observations were made of Mr Harvey at 8:00pm, 9:00pm, 11:00pm, 1:00am, 3:00am and 5:00am.[66] The only comments made with respect of any of those observation were:

Interaction with staff	*None*
Interaction with peers	*None*
Institutional behaviour	*Good*
Eating patterns	*None*
Sleeping patterns	*Good*
Changes in mood during shift	*None*
Changes in behaviour during shift	*None*
General comments or observations during shift	*Slept all night*

130. Mr Harvey was not sighted again until 7:40am when he was located deceased.[67]

131. The best evidence of his movements within the cell on the night of 12 November 2017 comes from Correctional Officer, Christopher Muggeridge.[68]

132. When he observed Mr Harvey at 8:00pm on 12 November 2017, he was sitting on the edge of his bed and "*did not respond to the [torch] light as normal*".

133. At 9:00pm, CCO Muggeridge observed Mr Harvey's position had changed and he was sitting on his bed with his back against the wall watching television. On this occasion he responded to the torch light by stating "*fuck off*".

134. At 5:00am on the morning of 13 November 2017, Mr Harvey was observed in his bed with a blanket on him. He responded to a knock on the cell door by pulling his blanket down to show his face. This is the last sign of life from Mr Harvey.

135. CCO Muggeridge finished duty at 5:30am. There was a change of shift at 6:00am.

136. Mr Harvey was not observed again until 7:40am when he was found deceased. He was found by Correctional Officer, Alan Flood who had commenced his shift at 7:00am.

137. The OCI Report found that "*no observation of Mr Harvey was undertaken after the 0500 observation, until the apparent good health check at approximately 0740 (2 hours and 40 minutes later), at which time officers discovered his body. Plainly, that lapse contravened the 120 minute physical observation requirement to which Mr Harvey was subject*." However, the Report noted it is not possible to conclude whether a physical observation of Mr Harvey at 7:00am would or could have prevented his death, as it is not possible to determine his time of death.

[66] Exhibit D10 – QCS Observation Log - At Risk Prisoner
[67] D13.9 – File notes and miscellaneous
[68] C1 - HARVEY DIC Report at T1.7

Autopsy results[69]

138. On 15 November 2017, Dr Nigel Buxton conducted an autopsy consisting of an external and internal examination of the body. He concluded that the cause of death was neck compression (hanging).

139. The examination showed a healing irregular wound over the right parietal region, which measured 15 x 10 mm and appeared to have been sutured at some point. The direction of the wound was ephalic and penetrated the full thickness of the skin and impacted the scalp aponeurosis. There was a drying abrasion around the front of the neck passing just above the larynx. This had a width of 12 mm.

140. Dr Buxton concluded that death was a result of neck compression following hanging. There was evidence of a close contact gunshot wound to the head. This was of a glancing nature and consistent with a low velocity round. Bruising to the brain was consistent with the concussive impact of the discharge of the firearm. There was no major sequelae to the injury identified on the brain.

Conclusions on Inquest issues

Findings required by s. 45

Identity of the deceased –	Thompson James Harvey
How he died –	Mr Harvey was remanded in custody at Capricornia Correctional Centre for serious offences including attempted murder following a domestic violence incident. He was initially assessed as being at medium risk of self-harm in prison and placed on hourly observations. This was reduced to low risk after two days. Mr Harvey intentionally hanged himself from the intercom box attached to the wall of his cell while incarcerated at Capricornia Correctional Centre.
Place of death –	Capricornia Correctional Centre, Etna Creek Road, Etna Creek, Queensland 4702
Date of death–	13 November 2017
Cause of death –	Neck compression (hanging)

[69] Exhibit A6 – Autopsy Report

Mental health and physical care and whether assessments conducted of Mr Harvey were appropriate.

141. I accept that the evidence established that those charged with Mr Harvey's mental and physical care adequately discharged their responsibilities.

142. The evidence of Professor Drummer was that Mr Harvey was not exhibiting any symptoms relevant to possible opiate withdrawal. His morphine was stopped on 10 November 2017 and replaced by Panadeine forte. The dose of the Panadeine forte was two tablets twice daily. This would be equivalent to about 6-10 mg morphine twice daily. I consider that the management of his pain and infection risk at the Mackay Hospital and the CCC was appropriate.

143. I accept the submissions from Counsel Assisting and QCS that the assessments of Mr Harvey by Ms McMurtrie and the RAT team were appropriate and reasonable, given the guidelines about risk levels in place at the time and the evidence available to them.

144. I agree that the assessments were a reasonable exercise of their clinical judgment, given that they were at CCC and able to assess Mr Harvey's demeanour and presentation, and how that correlated to what they were being told.

145. It was clear on the evidence that assessing suicide risk is not an exact science and Dr Polk accepted that reasonable minds could differ in relation to risk assessments. I acknowledge that risk assessment does not equate to prediction and suicide risk and it can fluctuate rapidly, as acknowledged by Dr Polk.

146. Ms McMurtrie's assessment of a medium level of risk took into account Mr Harvey's recent suicide attempt. She was aware of ongoing suicidal ideation prior to his reception at Capricornia Correctional Centre through emails that had been sent from Ms Hanschen. It was noted in her initial assessment that there had been suicidal ideation at the watchhouse. Ms McMurtrie noted that he denied any current ideation. He reported reconciliation with his partner and was adamant about that fact.

147. Ms McMurtrie took into account Mr Harvey's comment that there must be a reason for him to be alive after his gunshot wound, and the fact that two consultant psychiatrists at the Mackay Hospital who assessed him determined that there was no mental health diagnosis. Ms McMurtrie also noted in her interview with the Chief Inspector that he was future orientated and had the significant benefit of being able to assess his demeanour on entry to prison.

148. The initial medium level observations of one hour meant Mr Harvey was placed in suicide-resistant clothing and bedding. Ms McMurtrie also consulted with senior psychologist, Ms Hanschen, who agreed with the assessment.

149. Ms McMurtrie noted in her evidence that she was satisfied Mr Harvey was cooperating but was physically unable to complete the assessment. Notwithstanding, she had sufficient information to complete the risk assessment.

150. Dr Palk agreed that Ms McMurtrie's assessment was reasonable. Even if he might have assessed him as being a higher risk on that occasion, he noted his

assessment came with the benefit of hindsight and the limitation of not being able to have actually assessed his presentation.

151. By the time of the RAT assessments on 9 November 2017, Mr Harvey had been on hourly observations for two days. There were no notices of concern raised, and there were no issues of concern noted by any Correctional Service Officers conducting the hourly observations.

152. Ms Haddock's evidence was that he was presenting better by 9 November 2017. She noted that he reported his anxiety had resolved, repeating that his relationship had reconciled. She considered he had realistic future goals. He was open and willing to engage in the assessment, not expressing any suicidal ideation. In her opinion, there had been a further shift since the assessment with Ms McMurtrie. She noted that she conducted some checks with nursing staff about whether they had any concerns about Mr Harvey. She also noted that she spoke with Ms McMurtrie and took into account the earlier assessment.

153. Considering all the evidence, I accept the submission that the reduction of risk assessment to low was reasonable. Mr Harvey was still on two-hourly observations. Both Mr Clark and Ms Hanschen, the chair of that RAT panel, agreed with those assessments. Ms Hanschen noted that it was not unusual for somebody to be stepped down from a medium risk level to a low risk level within two days in the custodial setting.

154. Mr Harvey was on a medium observations regime for 3.5 days before he completed suicide, and there were no concerns noted by anybody who conducted those observations during that time.

155. While Dr Palk's evidence was that he would have maintained Mr Harvey on at least medium observations, he accepted that his opinions were given with the benefit of hindsight. Dr Palk correctly observed that severe anxiety was not likely to resolve within two days. However, he accepted that moods could fluctuate rapidly over a period of days.

156. I agree with the conclusion in the OCI Report that Mr Harvey's at-risk management could have been better managed if the staff involved had undertaken collateral checks of his self-reported protective factors and identified whether he had misreported his protective factors.

157. The recording of a greater level of detail in at-risk documentation (initial assessments, at-risk assessments, ARMPs, RAT minutes and SOs), including the rationalisation or reasoning for any decisions and determinations made by individuals and the RAT, was identified as a very important improvement to local practices at CCC. Possibly the most important matter identified concerning the at-risk management procedures at CCC was an apparent lack of documented consideration to an individual prisoner's risks and needs.

Placement of Mr Harvey and the frequency of observations

158. While the frequency of observations was sufficient, there was a missed opportunity with the observation that should have been made at 7:00am on the morning of 13 November 2017. However, I accept that there was no evidence during the course of the evening of 12 November 2017 or the early morning of 13 November 2017 to indicate that there had been any change in behaviour by Mr Harvey that might have suggested to any Corrective Services Officer that he was intending to take his own life.

159. Following Mr Harvey's death an internal review was conducted by the General Manager at CCC, and it was determined that any observations required between 6:00am and 7:00am are expressly allocated to the relevant supervisor of centre services who is rostered on from 6:00am. I accept that this issue has been adequately dealt with by the OCI recommendations and their implementation.

Comments and recommendations

160. Consistent with s 46 of the *Coroners Act*, the scope of the inquest included a consideration of whether any changes to QCS procedures or policies could reduce the likelihood of deaths occurring in similar circumstances, or otherwise contribute to public health and safety or the administration of justice.

Safer cells

161. In May 2021, I delivered the findings into the deaths of SVE and Dylon Ahquee, who died in a separate incidents as a result of hanging. In the SVE findings I recommended that "*the Queensland Government publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy*".

162. QCS has advised that upgrading older style cells at Arthur Gorrie Correctional Centre and Townsville Correctional Centre remains a priority and will publish its progress in upgrading cells on an annual basis in its Annual Report. QCS has also indicated "*it is not able to publish a strategy detailing future plans to implement safer cells as to do so would pre-empt the Queensland Government's budget process and the deliberations of Cabinet Budget Review Committee*".

163. I note that the 2022-23 Annual Report of QCS reports that 92.9 per cent of all secure cells have a safer cell design, equating to 7212 (95.5 per cent) built beds within secure safer cells. It was reported that every high security correctional centre has safer cell designs, and that in 2022–23, a state-wide program to address ligature points within detention units was commenced.

164. I also note that the Inspection Standards published under the *Inspector of Detention Services Act 2022* include as an indicator under Standard 39 (Prisoners are held in a safe environment where security is proportionate to risk and not unduly restrictive) that *"Prison cells are designed to minimise ligature points".*

Implementation of OCI recommendations

165. Richard Butcher, Chief Superintendent and General Manager, CCC provided a statement outlining the response by QCS to the OCI findings and recommendations, including documentary evidence relating to implementation action.[70] A table setting out the OCI recommendations is attached to these findings.

166. The QCS response to the OCI recommendations relevant to this inquest is set out below:

[70] Exhibit B30

OCI Recommendation 1

- The OCI Report found that apparent good health checks were not carried out in accordance with the relevant Custodial Operation Practice Directive and the Facility Security COPD. It was recommended that all correctional officers at CCC be provided with additional training or mentoring in relation to their responsibilities concerning the management of and response to an incident, including the requirements of apparent good health checks. On 11 December 2017, the General Manager of CCC distributed an email to all CCC staff that clearly stated the responsibilities of responding staff during an incident in accordance with COPD requirements. This included the requirement for Good Health Checks.

OCI Recommendation 3

- The OCI Report found that first officers responding to the incident did not alleviate the pressure on Mr Harvey's neck by taking his body weight and loosening or cutting the ligature from around his neck, as required in the Incident Response COPD. It was recommended that staff at CCC should be reminded of their responsibility to immediately alleviate the pressure on a prisoner's neck during a response to a hanging. OCI Recommendation 3 was addressed at the same time as Recommendation 1. This included a reminder about the Preservation of Evidence and the need to 'take the weight of the person or loosen or immediately cut free the noose'.

OCI Recommendation 5

- During the investigation, it was found that responding officers did not commence life-saving measures following the cut-down process. Further, the need to commence life-saving measures was not discussed among responding staff, and the reason for not commencing life-saving measures was not documented. It was recommended that all CCC staff undergo further training on their responsibilities and duties in circumstances involving a possible death in custody and medical emergencies, particularly with respect to the commencement and continuation of lifesaving measures. OCI Recommendation 5 was addressed at the same time as Recommendations 1 and 3. This included the requirements for first aid and the commencement and continuation of lifesaving measures. Staff are reminded of these requirements during annual first aid refresher courses.

OCI Recommendation 11

- The OCI found that the 'Initial Assessment At Risk Prisoner' did not provide sufficient information or explanation in relation to how the Provisional Psychologist balanced Mr Harvey's risks with his limited protective factors on 7 November 2017. It was subsequently recommended that CCC management and the Risk Assessment Team (RAT) ensure that the practice, use or adoption of any standard, automated or pre-populated wording in prisoner risk assessments cease as a matter of priority, and that specific risk and protective factors be listed in any risk assessment conducted. The Manager of Offender Development discussed using specific risk and protective factors in risk assessments with relevant staff and implemented recommendation 11 as a priority.

OCI Recommendation 15

- The OCI found that the At Risk Assessment Report completed by Correctional Supervisor Clark was not completed thoroughly and lacked sufficient information. Supervisors at CCC were to be reminded of their ability to assess the required information to make an informed and considered assessment of a prisoner's risk, including their responsibility to undertake collateral checking to ensure validity and accuracy of a prisoner's self-reporting. This recommendation was addressed by an email dated 17 April 2019 from the General Manager to all CCC staff reminding them of the requirement to complete appropriate reports and review all available information in accordance with At Risk Management COPD. A summary of Prisoner Telephone System recordings was included in the list of information provided.

OCI Recommendation 16

- While it may not have led to a different decision, the OCI report found that the RAT did not give reasonable consideration to Mr Harvey's placement in secure accommodation, including his request to be accommodated in the same unit as an identified peer. It was subsequently recommended that RAT members at CCC should be reminded of their duty to consider and verify the appropriateness of an at risk prisoner's accommodation, including the option to place a prisoner on 120 minute observations in the Health Centre or Detention Unit, and to recommend that a prisoner be placed in a particular unit and/or cell. This recommendation should be expressly recorded within the At Risk Management Plan (ARMP).

- Recommendation 16 was addressed by updating the At Risk Management COPD on 17 September 2018. Accordingly, RAT panel members must consider prisoner placement during RAT meetings which includes the placement of prisoners on all levels of observations in accordance with their assessed level of risk.

OCI Recommendations 18 and 19

- The OCI Report found that the implementation of the ARMP occurred prior to the ratification process being completed by the Deputy General Manager. Recommendation 18 was that staff at CCC should be reminded that the ARMP should not be implemented until the ratification process in completed. Further, Recommendation 19 found that that CCC RAT members should be advised that:

    - ARMP should contain up to date information from the most recent RAT Assessment Reports under the headings 'Current factors indicating that the offender is at risk of self-harm/suicide;
    - the practice of pre-populated forms with standard phrases such as *'on the balance of risk and protective factors it was recommended the prisoner....,'* is to cease and all assessments should contain supporting explanation, discussion or reasoning regarding the recommendations made; and
    - RAT Meeting Minutes should be prepared following the meeting so that members are not constrained in terms of physical space in which to record their reasoning and recommendations.

- Recommendation 18 was addressed immediately and it was communicated to relevant staff that an ARMP is not to be enforced until the ratification process is completed by the Deputy General Manager.

- The At Risk Management COPD now it states under 'Risk Assessment Team (RAT) Meeting that an "*ARMP must be developed and documented for each at risk prisoner*" and "*RAT members must consider all reports (including any current/recent At Risk Management Plans ...".*

OCI Recommendations 21 and 22

- The Inspectors held that no observation occurred at 7am on 13 November 2018, which was a direct breach of the ARMP and At Risk Management COPD. In accordance with Recommendation 21, the local CCC practice of one person sighting the prisoner and another signing the observation log should cease. Observations should continue to be done in pairs, but the officer sighting the prisoner and confirming apparent good health, should also be the officer who signs the observation log.

- It was also recommended that the General Manager at CCC review the local *'gentlemen's agreement'* of shift handover occurring 30 or more minutes prior to official shift end and address the situation where the day shift Correctional Supervisor is signing the observation log to confirm that the night shift observations were completed.

- All CCC staff were instructed to complete the observation logs in accordance with instructions from the OCI and the At Risk Management COPD. A review of the shift handover process was conducted by the General Manager of CCC, who did not consider it appropriate to direct staff not to commence their shifts early or not to conduct an early handover. The direction should only occur if the relief occurs outside of appropriate Award requirements.

- However, the General Manager addressed the situation where the day shift correctional supervisor was found to have signed the observation log to confirm that the night shift observations were completed. As per the Recommendation Implementation Form for Recommendation 22, the night- shift Supervisor is to sign off that the observations occurred under their oversight whilst present, regardless of when they complete their shift. Clarification was provided in a verbal briefing with supervisors.

OCI Recommendation 23

- The OCI Report found that insufficient information was provided to adequately explain the cancellation of Mr Harvey's safety order. It was subsequently recommended that psychologists at CCC should be advised to record sufficient detail to support their reasoning for cancelling a safety order, including making specific reference as to the cancellation of the order, and the reasons why, when recording the cancellation in both IOMS and the RAT minutes.

  Recommendation 23 was addressed by updating the At Risk Management COPD to add a section in the RAT Minutes for each RAT panel member to provide their view in relation to their consideration for a safety order. There is

also space in the form to state a reason At Risk Management strategies are discontinued.

OCI Recommendation 24

- It was found in the OCI Report that relevant staff did not raise a Self-Harm Episode History (SHEH) flag in IOMS and populate it with relevant information.

- It was subsequently recommended that all staff, and in particular Correctional Counsellors, should be reminded of the requirement to notify the Senior Psychologist of the need to raise a SHEH flag in IOMS and enter sufficient information, in accordance with the relevant COPD.

- QCS expects all staff, including psychologists and correctional counsellors, to maintain a contemporaneous knowledge regarding the requirements of their duties as detailed within COPDs and relevant procedures.

- In response to Recommendation 23, the At Risk Management COPD provides clear direction to staff regarding their responsibilities in relation to the raising of a SHEH flag and the assessment and management of prisoners at risk of suicide or self-harm. The COPD states "*the staff member who becomes aware of this information must notify the senior psychologist and correctional supervisor. The senior psychologist is responsible for activation of the Self-Harm Episode History (SHEH) warning flag in IOMS*".

- Psychologists and counsellors are required to participate in online induction training and structured mentoring within eight weeks of the commencement of their employment. The training incorporates an examination of the requirements associated with the assessment and management of prisoners at risk of suicide or self-harm, including those related to the raising of a SHEH flag and relevant COPDs.

- Consequently, all psychologists and correctional counsellors are informed of their responsibilities in relation to the raising of a SHEH upon commencement of their employment.

OCI Recommendation 25

- The OCI found there was information available to QCS at the time of the incident which indicated that Mr Harvey was less than forthright in the information he provided to CCC staff, and in particular his responses regarding his risk of suicide/self-harm.

- Recommendation 25 was that CCC officers responsible for assessing a prisoner's at risk status should be reminded to give consideration to all available information and how such information correlates with a prisoner's self-reporting. Officers should also be reminded to seek out information that may not be directly to hand in order to undertake collateral checks and verification of a prisoner's self-reporting, and give consideration to a prisoner's individual risks and needs.

- QCS expects that staff who are conducting At Risk Assessments and Reviews ensure that all available information is considered in accordance with the At Risk Management COPD. In September 2018, the At Risk Management COPD stated (in part) that: "*All staff involved in the management of prisoners have responsibilities and professional accountabilities in minimising harm and prevention of loss of life*".

- The At Risk Management COPD implemented on 17 September 2018 outlines under 'Reception Into Custody' that "*a psychologist or correctional counsellor is responsible for completing the Immediate Risk Needs (IRNA) upon a prisoner's admission. In completing the IRNA, collateral information should be sought by the assessing officer to obtain relevant information from all available sources - refer to Practice Directive Reception Processes: Admission and Assessments".*

167. Having regard to the recommendations made by the investigators engaged by the Office of the Chief Inspector and the QCS response to those, I make no further recommendations about those matters.

168. I close the inquest.

Terry Ryan
State Coroner
BRISBANE

Office of the Chief Inspector Findings and Recommendations

OCI Findings	OCI Recommendations
Finding 1: ***Apparent good health checks were not carried out in accordance with COPD Facility Security.***	**Recommendation 1:** All Correctional Officers at CCC be provided with additional training or mentoring in relation to their responsibilities concerning the management of and response to an incident, and that such training include the requirements of apparent good health checks.
Finding 2: ***First officers responding to the incident did not alleviate the pressure on Mr HARVEY's neck by taking the body weight of the prisoner and loosening or cutting the ligature from around his neck, as is required of the COPD.***	**Recommendation 2:** QCS should amend Appendix 13 to ensure clarity in the directive regarding keeping the knot intact. **Recommendation 3**: Staff at CCC should be reminded of their responsibility to immediately alleviate the pressure on a prisoner's neck during the response to a prisoner's hanging.
Finding 3: ***The response in cutting down the ligature was delayed because the officers had to retrieve a cut down knife from the office.***	**Recommendation 4:** QCS should amend the COPD Safety and Security Equipment so as to require those officers conducting apparent good health checks, headcounts or musters to have a cut-down knife in their possession regardless of whether they are on day or night shift. If multiple officers conduct the one check, count or muster, it would be sufficient if one of those officers (e.g. the supervisor) within the accommodation unit has the relevant cut-down knife in his or her possession.
Finding 4: ***Responding officers did not commence life-saving measures following the cut-down process. The need to commence life-saving measures was not discussed among responding staff, and the reason for not commencing life-saving measures was not documented in incident reports.***	**Recommendation 5:** All CCC staff undergo further training in their responsibilities and duties in circumstances involving a possible death in custody, and medical emergencies, particularly with respect to the commencement and continuation of lifesaving measures.

Finding	Recommendation
Finding 5: ***Management and staff at CCC did not physically complete and execute the 'Death in Custody Management Checklist (Admin Form 185)', as required by the 'COPD Exit – Death in Custody'.***	**Recommendation 6:** CCC management note that all COPD requirements should be met in the event of an incident, including physical completion and execution of incident management checklists.
Finding 6: ***The debriefing process was not conducted in accordance with the requirements of COPD Incident Management – Appendix 17. Level 2 debriefing was not completed.***	**Recommendation 7:** CCC staff be reminded of the requirement to conduct a level 2 operational debrief following an incident that at the very least includes a recording of the observations of responding staff members and an assessment of the management of the incident. **Recommendation 8:** QCS should amend COPD Appendix 17 to require Form 193: Debrief Workshop, to be used as a reference document for debriefing following future incidents, and that staff ensure all topics on Form 193 are covered in future debriefs.
Finding 7 ***The Provisional Psychologist was not able to complete, in full, the 'Initial Assessment At-Risk Prisoner Form (Admin Form 56)' and it is therefore unclear how a level of risk could be accurately determined.***	**Recommendation 9:** QCS should give consideration to amending the COPD to clarify what the words '*a complete assessment',* are intended to mean, (i.e. does this mean a full and complete assessment OR an assessment that, in the opinion of the psychologist, contains sufficient information that she/he is able to determine a risk rating and subsequent observation level). Any such amendment should clarify when a prisoner should be placed on an extreme observation level because of the inability of the psychologist to complete the assessment.
Finding 8 ***The 'Initial Assessment At-Risk Prisoner (Admin Form 56)' was completed by the Provisional Psychologist, seemingly in consultation with the Senior Psychologist, however no documentation exists of the content and result of that consultation.***	**Recommendation 10:** QCS should give consideration to amending the COPD to not only require consultation between an assessment officer and a psychologist be recorded in IOMS, but that this consultation should also be recorded by the assessment officer on the 'Initial Assessment At-Risk Prisoner (Admin Form 56)'.

Finding	Recommendation
Finding 9 ***The 'Initial Assessment At-Risk Prisoner (Admin Form 56)' does not provide sufficient information or explanation in relation to how the Provisional Psychologist balanced Mr HARVEY's risks with his limited protective factors, in assessing Mr HARVEY as a medium at-risk level on 7 November 2017.***	**Recommendation 11:** CCC management and RAT ensure that the practice, use or adoption of any standard, automated or pre-populated wording in prisoner risk assessments cease as a matter of priority* and that specific risk and protective factors be listed for any risk assessment conducted. **Recommendation 12:** QCS should amend the COPD Risk Management so as to require professional psychological staff members to expressly disclose the reasoning supporting their recommendations, specific to the assessed risks to and needs of to that particular individual. ***It is noted that CCC has actioned this recommendation as an immediate priority.***
Finding 10 ***The Initial Assessment Prisoner At-Risk process was not completed in full, and insufficient criterion was presented to justify placement of Mr HARVEY on 60 minutes observations***	**Recommendation 13**: QCS should amend Appendix 5 - Risk Level/Observation Guidelines so as to make it clear that in the event protective factors cannot be discussed with a prisoner, or insufficient protective factors are able to be identified, the prisoner cannot be assessed lower than at a high risk level (subject to 15 or 30 minute observations). ***Inspectors note that QCS have made amendments to Appendix 5 since the death in custody of Mr Harvey to incorporate this as an indicator for high risk observations.***
Finding 11 ***The At-Risk Assessment Report completed by CS CLARK was not completed thoroughly and lacked sufficient information.***	**Recommendation 14:** QCS investigate the development of a training package for Correctional Supervisors who perform At-Risk Assessments, that includes training in undertaking of risk assessments, and the information required to be collated, summarised and inserted into the At-Risk Assessment Report. **Recommendation 15:** Correctional Supervisors at CCC, be reminded of their ability to access the required information to make an informed and considered assessment of a prisoner's risks, including their responsibility to undertake collateral checking to ensure validity and accuracy of prisoner self-reports.

Finding	Recommendation
Finding 12 ***The recommendation by the RAT to reduce Mr HARVEY to 120 minute observations on 9 November 2017 could not have occurred if he had been placed on a higher level of observation (15 or 30 minute) at time of admission.***	
Finding 13 ***While it may not necessarily have led to a different solution the RAT did not give reasonable consideration to Mr HARVEY's placement in secure accommodation, including his request to be accommodated in the same unit as an identified peer.***	**Recommendation 16:** RAT members at CCC, should be reminded of their duty to expressly consider and verify the appropriateness of an at-risk prisoner's accommodation, including the option to place a prisoner on 120 minute observations in the Health Centre/Detention Unit, and to recommend that a prisoner be placed in a particular unit/cell. This recommendation should be expressly recorded within the ARMP. **Recommendation 17**: QCS should clarify the COPD Risk Management in respect to what is meant by the phrase 'reduced hanging points' and an assessment should be undertaken as to whether or not secure accommodation at CCC meets that requirement, in order to provide certainty for staff and management*. ***Inspectors note that QCS have made amendments to COPD Risk Management to include this recommendation.***
Finding 14 ***Implementation of the ARMP occurred prior to the ratification process being completed by the A/DGM.***	**Recommendation 18**: Staff at CCC should be reminded that the ARMP should not be implemented until the ratification process is completed. **Recommendation 19**: RAT members be advised that: • ARMP should contain up-to-date information from the most recent RAT Assessment Reports (Form 64) under the headings *'Current factors indicating that the offender is at risk of self-harm/suicide'.* • The practice of pre-populated forms with standard phrases such as '*On the balance of risk and protective factors it was recommended the prisoner…*', is to cease and all assessments should contain supporting explanation, discussion

	or reasoning regarding the recommendations made. • RAT Meeting Minutes should be prepared following the meeting so that members are not constrained in terms of physical space in which to record their reasoning and recommendations*. ***Inspectors note that QCS have made amendments to COPD Risk Management and this issue has been addressed in the new COPD.***
Finding 15 ***Lack of reasoning provided for the RAT decision not to provide suicide resistant bedding and/or clothing to Mr HARVEY as required by the Local Instruction – At-Risk Management.***	**Recommendation 20:** Even if a prisoner is assessed as a low risk, the CCC RAT should expressly consider whether a prisoner should be subject to suicide resistant clothing and/or bedding and expressly provide their reasoning as to this determination when completing the ARMP*. ***Inspectors note that QCS have made amendments to COPD Risk Management and addressed this issue.***
Finding 16 ***0700 observations on 13 November 2018 were not completed in direct breach of the ARMP and COPD Risk Management.***	**Recommendation 21:** The local CCC practice of one person sighting the prisoner and another signing the observation log cease. Observations should continue to be done in pairs, but the officer sighting the prisoner and confirming apparent good health, should also be the officer who signs the observation log. **Recommendation 22:** The GM review the local *'gentlemen's agreement'* of shift handover occurring 30 or more minutes prior to official shift end and address the situation where the day shift correctional supervisor is signing the observation log to confirm that the night shift observations were completed.
Finding 17 ***Insufficient information was provided to adequately explain the cancellation of Mr HARVEY's safety order.***	**Recommendation 23:** Psychologists at CCC should be advised to record sufficient detail to support their reasoning for cancelling safety orders and make specific reference as to the cancellation of the order, and the reasons why, when recording the cancellation of the order in both IOMS and the RAT minutes.
Finding 18 ***Relevant staff did not raise a SHEH flag and populate***	**Recommendation 24**: All staff, in particularly Correctional Counsellors, should be reminded of the requirement to notify the Senior Psychologist of the need to raise a SHEH flag in IOMS and enter sufficient information into the SHEH flag, in accordance

it with relevant information.	with the relevant COPD.
Finding 19 ***Other relevant information was available at the time of the incident, which indicated that Mr HARVEY was less than forthright in the information he provided to CCC staff, and in particular his responses as to his risk of suicide/self-harm.***	**Recommendation 25**: CCC officers responsible for assessing a prisoner's at-risk status give due consideration to all available information and how such information correlates with a prisoner's self-reporting. Officers should also seek out information that may not be directly at hand in order to undertake collateral checks and verification of a prisoner's self-reporting in order for due consideration to be given to a prisoner's individual risks and needs.
Finding 20: ***Cell infrastructure in secure accommodation units at CCC contains potential hanging points.***	**Recommendation 26:** QCS investigate the feasibility of changing infrastructure of secure accommodation areas to provide 'safe cells' and investigate whether any intercom boxes of similar design are proposed for accommodation units yet to be completed and whether it is feasible to change the design to make such boxes more suicide resistant.