FINDING IN THE INQUEST IN TO THE DEATH IN CUSTODY

AT BATHURST CORRECTIONAL CENTRE OF

BRIAN DUNNINGHAM

This has been an inquest into the death of Brian Dunningham, who died at Bathurst Correctional Complex (BCC) at some time between 11pm on 10 Sept 09 and 8.20am on the following morning.

Family have asked that we refer to him as Brian.

At his death, he was only 42. He leaves behind a loving family, his Mother Betty, father Duncan, brothers, Michael and Stephen, sisters Jennifer, Adrian and Christine.

My primary function is provided by s. 81 of the Coroner's Act. 2009. It is to make findings as to

(a) The identity of the deceased
(b) The date and place of the person's death
(c) The manner and cause of the person's death.

There is no controversy in this case as to identity or place of death.

The medical cause of Brian's death, according to the pathologist, Dr Samarasinghe, was hanging, and there was a ligature mark around the neck.

The evidence leaves no doubt that the hanging was self inflicted and that Brian took his own life. There were:

- no signs of physical struggle on body
- no physical indicators in cell
- he was on good terms with his cell mate, Michael Pollard, who was separated and interviewed immediately after Brian was discovered, and who appeared genuinely shocked
- Mr Pollard had no injuries.

The real question in this inquest concerns the manner of death - In other words, what were the circumstances that led up to Brian taking his own life.

A secondary, but equally important, function is created by s. 82 of the Act. This section enables a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with the death. Public health and prison reform have been the subject of recommendations both by myself and Coronial colleagues in New South Wales in and around Australia. In particular, I will refer to recommendations which I made in 2010 to the Minister for Corrective Services and the Minister for Health following a death by hanging at Goulburn Correctional Centre and the response to those Recommendations.

CIRCUMSTANCES

Brian was brought into custody on 8 March 2009, and after spending several nights in Surry Hills watch house, he was taken to Parklea jail on 11 March.

Brian had been in custody in a number of jails in NSW at various time of his life, so this was not a strange experience for him.

In April, Brian was sentenced in the Local Court for 2 counts of Assault Occasioning Actual Bodily Harm and breaching a Domestic Violence Order. The sentence was for 18 mths, with 12 months Non-Parole Period, which was due to expire on 7 March 2010.

However he was also on remand for a charge of robbery in company, allegedly committed with his co-offender, Ms Vitnell, who had been his defacto (and was the victim of the domestic dispute).

On 11 March, an Intake screening form completed by Corrective Services staff noted a previous admission at Gladesville Psychiatric Hospital. It was also noted that Brian was prescribed Avanza for depression but denied he had any current self harm/suicidal thoughts. He was cleared for normal cell placement.

Appropriate screening documents were completed by Justice Health staff. This included a Kessler 10 self assessment form, designed to assess the risk of self harm or suicide. On 11 March 2009, Brian reported that he did not have thoughts of self harm or suicide and there was nothing to alert Justice Health to a problem. When he came into custody he was on a dose of Avanza (anti-depressant) and methadone, and those drugs were continued.

However, there were a number of early indicators whilst Brain was in custody at Parklea that he was not well.

On 23 March Brian was assessed by Dr Chew, a Psychiatrist. Brian was fearful of being killed and hearing voices. Added 10mg of Olanzapine (Zyprexa), an anti-psychotic.
On 30 March Brian was assessed by Dr McLure, psychiatrist. He was hearing voices and reported being in danger.
On 30 April he was assessed again by Dr McLure. Olanzapine reduced to 5 mg at night : to be stopped altogether on 15 May.

On 16th July, he was taken to Bankstown Hospital suffering chest pains. An ECG and other tests were done. They returned negative results and he was returned to his cell the same day.

On 17 July, Brian was seen in the clinic at Parklea Jail for a pre-court flu screening because he was due to appear in court for the robbery offence. On arrival, he asked when he was going to see the Psychiatrist, and stated "I have already sent in two referral forms. I need to see the psych urgently otherwise I will kill myself".

An hour later, he was asked about the seriousness of those threats and whether he needed to be in the clinic for his own protection. At that stage, Primary Health Notes record that he said that he was "ok" but that he really needs to see the psychiatrist because the voices are coming back. He was noted to be presenting as calmer and more accepting at that stage.

A mandatory Notification for Offenders at Risk of suicide or self harm was completed and an RIT (Risk Intervention Team) was convened . Brian was housed in a cell with CCTV and 15 minute observations, nil sharps were allowed, and he was only permitted safety blankets.

Brian was assessed again on 18 and 19 July by Justice Health staff. He was noted to be co-operative and talkative, and he denied thoughts of self harm or suicidal ideation. He told staff that he was just starting to realize what he had lost – a good job, earning plenty of money, his supportive parents and brothers. It was noted that he was to be referred to a psychiatrist.

On 20 July, Brian was reviewed by the Risk Intervention Team (RIT) and it was decided that he could be returned to a normal cell.

Just 3 days later, on 23 July, Brian presented to the clinic again. He reported to staff that 3 inmates had stood over him for money and he was fearful of them. He was placed on a SMAP order (Special Management and Protection) to commence on that day and expire on 22 January 2010. The effect of the order was that he was not to associate with those 3 inmates.

The last time Brian was seen by a psychiatrist was on 29 July, when he saw Dr Chew for the second and final time. Dr Chew recorded that he was :"freaking out". He had suicidal ideation, but told the doctor that he "hasn't got the guts". The notes indicate that Brian had a history of methadone use - he believed that the drug had ruined his life and he wanted to reduce his intake. That thought was one that reoccurred for Brian. Dr Chew noted that he was for urgent psychiatric review in one week's time. He did not place a medical hold on him.

In Parklea, Brian had developed a friendship with his cell mate, Charles Gadsden. A letter sent by Mr Gadsden to Brian whilst he was at Bathurst gives us some insight into Brian's state of mind. At the end of a friendly, warm letter to his new friend, Mr Gadsden wrote: "take care buddy. I don't want you to do anything stupid now. Be safe'. When asked to explain why he had written those words, Mr G said that while they shared a cell at Parklea, Brian had told him that he wanted to kill himself until Mr G arrived. Brian told him that he was depressed because all his brothers were successful and he had wasted his life using drugs.

Brian was able to see family in Parklea and he received regular visits from his parents and his brother. According to Stephen Dunningham, Brian often said to Stephen that he wanted to see a psychiatrist or a psychologist for something, but he was not sure exactly what for.

On 5 August, Brian was transferred to BCC, whilst he awaited movement to Wellington, his jail of classification. Evidence was given that some 1200 movements, or transferring inmates, come through BCC monthly.

One of the frustrations for Brian's family with his transfer to Bathurst was that it was too far away for them to visit him. Brian was able to make some calls to his family, and received letters from his mother. The last call he made to his family was on 9 September, 2009, when he spoke with his mother, father and brother Stephen. Stephen mentioned to him that his co-offender for the robbery charge, previously his girlfriend, would be pleading guilty with the

potential of giving evidence against him. Brian made a point of apologizing to his brother Stephen and to his father. He told his mum that he had got himself right with God and expressed his love for her, and he asked for Stephen to come back on the phone and then told his brother that he loved him.

It is abundantly clear that Brian had a deep love for his family and he felt loved and supported by them.

During his incarceration at Bathurst, Brian did not see a psychiatrist, welfare worker, education officer or Drug and Alcohol worker. However, in the last week of his life, he did see a doctor and several nurses, for the reasons I will set out.

7 September – Dr Rikard-Bell, a visiting GP at the Clinic, saw him for a serious rash on his legs. He provisionally diagnosed the rash as vasculitis, possibly due to an allergic reaction to his medication. The GP stopped the Zyprexa and prescribed Prednisone, a corticosteroid at 50mg, plus anti-biotics.

On 8 September, Justice Health staff were called to the yard after Brian collapsed. He had hypertension and staff were initially fearful that he may be suffering a heart attack. Brian was taken to Bathurst Base Hospital. He was diagnosed as having had a stress or anxiety related attack and returned to custody.

On 9 September, Brian did not see the clinic. A notation filled in by Nurse Hurst for that date was a mistake, and in fact related to her seeing him on 10th September.

10 Sept 2009.

At around 9.30am, Nurse Pauline Hurst saw Brian at the clinic after being told by a Corrective Services officer that he wished to speak to a nurse. She noticed that he appeared agitated and tired. It appears that C S staff were approached by an inmate who alerted them to the fact that Brain was "acting weird" and may need some help. Brian himself then saw an officer and agreed to be taken to the clinic.

We now know that what Brian said to Nurse Hurst is critical to determining his mental state that night. Brian told Nurse Hurst that he was going mad and thought he was condemned to

eternal damnation because he had gone against God's word. He asked to see a priest and Nurse Hurst reassured him she would contact the chaplain. She did do so but he wasn't in his office and left a message explaining that Brian wanted to see him. We now know that the message wasn't received by the chaplain until after Brian had died.
He told several inmates that day that he was 'going to die tonight'. One of them was concerned sufficiently to break the usual code of silence and tell an officer of his concerns for Brian.
It may be significant that Brian returned to the theme of methadone when talking to Nurse Hurst on 10th September. He told her that he had made a mistake commencing methadone 20 years ago because it had been the easy way out. He also said he was "going mad' and was 'condemned to eternal damnation'. The Nurse attempted to reassure him.

Dr Sandra was conducting a clinic at that time and, at the suggestion of Nurse Hurst, he saw Brian briefly. He noted "allergic welts" and recommended a continuation of prednisone at the dose of 50 mls per day. No discussion occurred regarding Brian's mental state. Brian then spoke again to Nurse Hurst.

At 8.30pm: Enrolled and Endorsed Nurse Flynn checked on Brian in his cell, after being asked to check on him by a nurse from the morning shift. Nurse Flynn told the court that she asked why and was told by her colleague that she 'just had a feeling'. Brian assured her that he was ok, and did not need any medication, or to talk to anyone. She considered him to be calm, directly looking her in the eye, and not delusional. Dr Nielssen opined that it is not unusual for calm to descend when a person has made the decision to commit suicide.

On the evening of 10 September, Brian was sharing his cell with fellow inmate Michael Pollard. Other inmates and CS staff suggest that Brian and Michael were both relatively easy going prisoners and they got along well. Both attended the chapel on various occasions. There was no history of tension between the two. Unfortunately, Mr Pollard, who has been released, has not been able to be found to give evidence at this inquest.

Michael and Brian watched TV together that night. Michael recalls a special "Q and A" where the then Prime Minister, Mr Rudd was on, and the TV guide for that date shows that to be the case. He noticed nothing out of the ordinary on that night and theTV went off around 10.30pm.

ACTIVE ALERTS

Brian had a number of active alerts placed on him, as follows:

9 and 11 March 09– Med alerts he was on methadone

19 August 09 – Association alerts not to associate with 3 inmates – (Andrew Zhang, Adam Drollet, and Shadi Derbas).

19 August 09 – Medication alert – Mirtazapine/Olanzapine

11 Sept 2009

Brian's body was located on the morning of 11 September at around 8.25am, by Officer Peter Stace. At that time, Officer Stace entered the cell for the routine morning "let go". Michael Pollard appeared to be still asleep and Brian was suspended from the lower bar of the cell window, by a prison sheet which was knotted round his neck.

Officer Stace immediately yelled for assistance, and he was quickly joined by Officers Potter and Madden. They helped to cut the bed sheet and the body was brought down. No CPR was attempted by Prison Officers because the body was cold and stiff, and it was clear that he had been dead for some time. It certainly appears that Brian had been deceased for at least several hours, so that there was nothing they could have done at that point to save his life.

Within minutes of Brian being found, nursing staff arrived to assist. Brian was noted to be cold to the touch, and there were no signs of life.

All Standard Operating Procedures were complied with. The crime scene was secured, a video recording was made so that relevant evidence could be preserved and the cell was secured to await the arrival of police, who, in accordance with protocol, were notified of the tragedy and attended promptly, arriving at the jail at around 8.45am.
They then took over the crime scene preservation and the investigation.

I heard evidence from two police officers who attended the jail immediately after they were notified. They were the Officer In Charge Detective Senior Constable Andrew Mclean, and Senior Constable Matthew Cullen from Forensic Services group.

They noted that there was a large number of possible hanging points in the cell, at least 8. Officer Cullen was able to take photos of cell bars in Brian's cell, and compare them to the

bars in other cells. He noted that there was no mesh on the window ofCell 36 that would prevent a sheet being looped through to allow for a hanging point.

THE VIEW

Following the opening of this inquest, I, my Assisting Counsel and Solicitor, and the legal representatives for Justice Health, Corrective Services, the nurses, and the Dunningham family were shown around the relevant areas of BCC by the General Manager, or Governor, Mr Fittler. We viewed the cell in which Brian died in D wing, the Clinic, the accesses, the Acute Crisis Management Unit, and the new facility almost completed for women prisoners, the latter two units being designed to minimize the risks of suicide in their outlay, their furniture, and in the case of the ACMU, the installation of CCTV in all cells. Those two new units were admirable, and a credit to the management of Bathurst. Unfortunately, the antiquity and crowding, and no doubt the lack of funding, in the main gaol, including D wing, is a far cry from those humane and desirable modern facilities.

The huge number of transferring inmates passing through Bathurst makes treatment plans difficult, if not impossible, to implement. The Clinic is placed so that Protection prisoners, such as Brian, can not directly access it as do other prisoners, and special clearances are required for their escort to the Clinic.

There is only one, full time position (shared by two nurses) of Mental Health Nurse. The current incumbents, while now experienced and Registered Nurses, do not hold formal qualifications in mental health. Their daily workload allows no more than six patients to be seen daily, and the current waiting list is 90, as compared to 50 two years ago. There are 3 full time psychologists at the gaol, employed by Corrective Services rather than Justice Health. A psychiatrist is available one and a half days per fortnight. It is simply impossible for proper health care, both physical and mental, to be provided to the over 500 inmates of Bathurst by the current number of Justice Health staff.

The commitment and compassion of Mr Fittler and his senior staff was impressive. However, commitment and compassion need to be supported with better staff resources and greater funding. It is noted with pleasure that, three weeks before this inquest began, funding was received for non-risk meshing to be installed on cell windows instead of the dangerous bars which were used by Brian. Transition (or Buddy)cells are being prepared. But the majority of the gaol still consists of cells where there are multiple hanging points including in the

furniture and inadequate windows, heating and facilities generally. As prisoners are locked down from about 2.30 pm until let-go at 8am, the security and comfort of their cells should be paramount particularly given the high occurrence of existing mental illnesses in the prison population.

The Issues

1. Were there obvious hanging points in the cell shared by Brian Dunningham, and if so, was it appropriate to house Mr Dunningham in that cell, given his medical history?

2. Were staff at BCC adequately appraised of any mental health issues suffered by Brian Dunningham?

3. Did Brian Dunningham receive adequate care for his mental health issues whilst he was at BCC? What link, if any, does this have to his death?

Expert Evidence

Dr Olav Nielssen, a psychiatrist, gave his expert, independent opinion of care and treatment afforded Brian Dunningham both at Parklea and at Bathurst.

Dr Nielssen agreed with the prescribing to Brian by Drs Chew and McLure of the antipsychotic olanzapine and also of the addition of the antidepressant mirtazapine. However, given that the presence in Brian of symptoms of psychosis months after reception to prison is consistent with an underlying psychotic illness, rather than a transient or drug-induced state, his view was that olanzapine should have been continued and not ceased on 14 May.

While the various medications prescribed were on the whole appropriate, when Dr Chew recommenced the Olanzapine at a relatively low dose on 29 July, Dr Nielssen's view was that it was less than the normal therapeutic dose for psychotics and probably too low to control properly the symptoms. He felt that the reason for its cessation on 7 September by Dr Rikard-Bell, i.e that it may have been the cause of the allergic rash, was 'possible but unlikely'. He was critical of the inadequacy of the level of observation and the frequency of review, given Brian's initial diagnosis, treatment and history. Most specifically, he was highly critical of the transfer to Bathurst without warning on 5 August, the day he was due to have the urgent psychiatric review, and the inaction of the Justice Health staff at

Bathurst in arranging an urgent mental health review for Brian. “Overall, “ he states, “ the psychiatric care provided to Mr Dunningham was less than adequate”.

Dr Nielssen also comments on the inadequacy of the notes or case files which lack any detail to assist review and treatment plans. He notes that ‘from entries in the Justice Health records, it does not seem that Mr Dunningham had any psychological care at Bathurst CC, apart from the continuation of psychotropic medication prescribed while he was at Parklea. It does not seem that he was placed on a list for urgent psychiatric review…..(nor) provided with further treatment for psychosis or referred for further review by a mental health nurse at that time’.

The psychiatrist in oral evidence also withdrew any real criticism of the GP’s cessation of the Zyprexa, as it was, he said, possible but unlikely that Zyprexa caused the rash, and he thought it probable that Brian was already in a psychosis. The prednisone, a steroid, however, in such a large dose, does apparently have mood effects. He told the court that it is only a possibility that ceasing anti-psychotic medication contributes to instability.

Under cross examination by Mr de Mars for the family, Dr Nielssen stated that he considered the main reason for the suicide to have been the disruption to his care by the transfer and the failure adequately to treat his known and severe mental illness. Brian was a prisoner with complex physical and mental health needs, so that consistency of treatment was vital. He should not have been transferred from Parklea. There should have been a review of his Justice Health notes by staff at Bathurst.

THE FAMILY

Stephen Dunningham, Brian’s brother, spoke passionately of the family’s views. He himself had once spent time in prison, and also spoke from his personal experience. He considered that there were no proper resources at all for prisoners. There was no choice at all regarding transfers and placements. The Justice Health and mental health care was virtually non-existent. A prisoner was “a second rate citizen if on methadone, and a third rate one if also on protection”. All the signs of risk were there for Brian, who was crying out for help, and none was forthcoming.

CONCLUSIONS

Nothing said by Dr Nielssen was contradicted and I accept it as strong evidence from a highly qualified psychiatrist experienced in the prison system.

I am sympathetic to the feelings of the family, and do not dismiss Mr Stephen Dunningham's opinions, having now presided on a number of inquests into prisoner suicides. I do recognize however that management at Bathurst is making impressive efforts to improve overall care for inmates, and that Corrective Services has taken strong and effective steps in the last year or two particularly to reduce instances of suicide in its institutions. It has been successful in that reduction, by introducing multi-disciplinary reviews of prisoners at risk, using observation cells and CCTV, and the 'buddy ' system of two in a cell, and reducing, in many instances, hanging points in cells. But one suicide is one too many in a system with a duty of care. As Dr Nielssen's report stated, " there are a huge number of transfers between gaols in New South Wales, which for security reasons are usually done without notification or consultation, and often result in the disruption of continuity of care. Moreover, the level of psychiatric care available outside the Long Bay and Silverwater gaols is generally below that required to treat all patients with mental illness".

I take judicial notice of the fact that in the civilian community, provision of mental health care has been sparse and inadequate, and that only recently has government recognized that funding for community care needs to be vastly increased. Given the incidence of mental illness in the prison population, that need is proportionately even greater.

It was, as learned Counsel Assisting submitted, a serious lapse that Brian Dunningham was not seen by a psychiatrist (or even a mental health nurse) at Bathurst despite missing Dr Chew's one week review. Nurse Homan was not able to explain the oddities of files concerning that omission even though she had put him on her list as urgently needing an appointment. It seems it will not be explained why or even whether he actually was 'dropped from the waiting list'. No health professional at Bathurst read his files. This is unforgiveable in view of his known history. Without necessarily blaming any individual staff member, here was a serious systemic failure to ensure the continuity of intensive psychiatric care both at Parklea to some extent, and fully at Bathurst.

Are we serious about the prison system's goal being "correction", or "rehabilitation" when a

prisoner voluntarily coming off methadone, and with a history of psychosis, drug-induced though it may be, is not backed up with all the psychiatric help he needed?

In 2010 I made a number of recommendations following an inquest in to the death of a prisoner at Goulburn Correctional Centre. I commend the Department of Corrective Services for acting upon those recommendations relevant to it, and in establishing a special Management of Deaths in Custody Committee. A Coronial representative is an invitee on that Committee, as is the CEO of Justice Health. I regret having to comment that one of the Recommendations was to the Minister for Health and Justice Health. It read 'that there should be compulsory mental health training for all nursing staff in Justice Health'. Unlike the response of the Department of Corrective Services, that Recommendation, according to the evidence in this inquest, has apparently fallen on barren ground*. I will repeat it, and deplore the inaction of Justice Health.

RECOMMENDATIONS

A. To the Minister for Health and Justice Health:

1. That there be compulsory mental health training for all nursing staff employed by Justice Health, according to the recommendation made after the death of Paul Hogan at Goulburn Correctional Centre.

2. That Justice Health implement an urgent review of all aspects of the care and treatment of Brian Dunningham from his reception into the prison system in March 2009, until his death on 10 September 2009, to be provided to both the CEO and the Chairperson of the Board of Justice Health by the last day of September, 2011.

3. That there be an urgent review of staffing levels at Parklea Prison and in particular Bathurst Correctional Centre(s) to address the growing waiting lists for inmates requiring the services of Mental Health Nurses and/or Psychiatrists, taking into account the forthcoming opening of a new Clinic at Bathurst and the large number of transferee inmates. At least one further full time mental health nurse position to be considered for appointment to each Centre.

B. To the Minister for Corrective Services, and the Minister for Justice Health :

1. That consideration be given to ways of improving access to Health Care for inmates on protection or in the SMAP programme.

2. That consideration be given to amending Clause 297 of The Crimes Administration of Sentences Regulation 2008 to allow for details of the special needs of inmates with mental health issues to be given to Corrective Services staff responsible for the transfer of prisoner in order that they be taken into account

3. That consideration be given by the Department of Corrective Services to the allocation of a Case Officer to an inmate immediately after a Case Plan is developed, regardless of whether the inmate has reached the gaol of classification.

FORMAL FINDING

That Brian Gerard Dunningham died at Bathurst Correctional Complex sometime between the evening hours of September 10 and the early morning of September 11, 2009, by hanging, which was self-inflicted while suffering from a serious mental illness.

Magistrate Mary Jerram — July 7, 2011

New South Wales State Coroner — Chambers, Bathurst.

* Since completing the Finding above, the State Coroner is pleased to have been advised by representatives of Justice Health that Recommendation A1, made for the second time, has been accepted by Justice Health, and is in the process of being implemented

Note: An order under section 75(5) has been made permitting publication of a report of these proceedings.